1

FOR STATE HEALTH DEPT

M

99

I

0

2

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04866 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04865

1. **PLACE OF DEATH**
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kent Village
d. STREET ADDRESS: 2807 Forest Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Monica — Middle: Rose — Last: Alder

4. **DATE OF DEATH**: Month: April — Day: 20, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 14, 1960

9. AGE (In years last birthday): 1 yr. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willard Lee Alder Jr.

14. MOTHER'S MAIDEN NAME: Barbara Ann Van Pelt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Willard Lee Alder Jr. — Address: smae as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one ceuse per line for (e), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e): Respiratory failyrs — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Myasthenia gravis
DUE TO (c):
Conditions, if eny, which gave rise to immediete ceuse (e), steting the underlying cause last.

744.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert f or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While et work ☐ Not While et work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒, and in my opinion death resulted from: Natural causes XX. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 4/20/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/23/62

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

22d. LOCATION (City, town, or country) (State): Washington D. C.

23. FUNERAL DIRECTOR: Francis Gasch's Sons — ADDRESS: Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: APR 24 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04867

CERTIFICATE OF DEATH

04866

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Forestville
c. LENGTH OF STAY IN 1b: 6 mons.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3337--Senator Ave. S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa. b. COUNTY: Westmoreland Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ligonier
d. STREET ADDRESS: Star Rt # 711 South
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75 X 3

3. NAME OF DECEASED (Type or print): First: LILLIAN — Middle: MAY — Last: APPEL

4. DATE OF DEATH: Month: April — Day: 12 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 18, 1883
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Albright
14. MOTHER'S MAIDEN NAME: Mathilda Groft

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Alice Lammert 3337-Senator Ave. S.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Arteriosclerotic cardiovascular disease — 15 yrs
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-5 1962 to 4-12 1962 that (I) (we) last saw the deceased alive on 4-10 1962 and that death occurred at 1P M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas F Cleary M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Thomas F. Cleary M.D.
22d. ADDRESS: 5558 Silver Hill Rd. District Heights 28, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 16 -62
23c. NAME OF CEMETERY OR CREMATORY: Alleghany Co. Memorial Park
23d. LOCATION (City, town, or county) (State): Pittsburgh, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Brothers
ADDRESS: 1661- Good Hope Road SE. Washington 20, DC.
25a. REC'D BY REGISTRAR DATE: APR 16 '62
25b. REGISTRAR'S SIGNATURE: Curtiss L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04868 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04867

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kennelworth
c. LENGTH OF STAY IN 1b: 12 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1607 Eastern Avenue

2. USUAL RESIDENCE (Where deceased livad, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Kennelworth
d. STREET ADDRESS: 1607 Eastern Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alexious — Middle: A. — Last: Baker

4. DATE OF DEATH: Month: April — Day: 9 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept.18,1886

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Navy Yard

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Fannie Prosperi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): ~~NO~~ Yes W.W.I

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Grace Webb Bulloch, 3009 -37th.St., N.W. Address Washington, D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO (b): Myocardial insufficiency
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: April 9, 1962

EXAMINER'S NAME (Type): James I. Boyd
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/11/62

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or country) (State): Washington, D.C.

23. FUNERAL DIRECTOR: W.W. Chambers Co. — ADDRESS: Riverdale, Maryland

24a. REC'D BY REGISTRAR DATE: APR 17 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kramer

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04869

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04868

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hyattsville
d. STREET ADDRESS: 3402 54th., Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Moncure; Last: Barlow

4. DATE OF DEATH: Month: April; Day: 16; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 11, 1920

9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): S.P. 5

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Moncure Barlow

14. MOTHER'S MAIDEN NAME: Romero

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes
(If yes give were or dates of service): 1943 - 1962

16. SOCIAL SECURITY NO.: 230-03-6950

17. INFORMANT: Helen Martha Barlow
Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute occlusion of Coronary Artery
420.1
DUE TO (b): Hemorrhage in Atheromatous Plaque
Conditions, if any, which gave rise to immediate cause (a), steting the underlying cause lest.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James D. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 4/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4/19/62

22c. NAME OF CEMETERY OR CREMATORY: Arlington Mtl.

22d. LOCATION (City, town, or country) (State): Arlington, Va.

23. FUNERAL DIRECTOR: W.W. Chambers Co.
ADDRESS: Washington DC

24a. REC'D BY REGISTRAR DATE: APR 18 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04870 — Items 18 & 21, Film G-312 5/7/62.cac. — 04869

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 4489 Brooks Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Henry — Last: Barth

4. DATE OF DEATH: Month: April — Day: 28, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 15, 1917

9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assistance Manager Peoples Drug

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Barth

14. MOTHER'S MAIDEN NAME: Lillian Walters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 136-05-3363

17. INFORMANT: Jean Hess Barth — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (PENDING) Acute hemorrhagic necrosis of gastro intestinal tract.

971.3

DUE TO (b) Ingestion of ammoniam hydroxide

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): Grand Mal Epilepsy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, (Undetermined manner) ☒

ACTUAL SIGNATURE: Paul a Van Natta M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/28/62

EXAMINER'S NAME (Type): Paul Van Natta, M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 2, 1962

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery

22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR: Simons Bros.

ADDRESS: 1661--Good Hope Rd., SE Washington 20, DC

24a. REC'D BY REGISTRAR DATE: MAY 1 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kunz

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04871

CERTIFICATE OF DEATH

04870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges County — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 15 Min.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince Georges County
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt
   d. STREET ADDRESS: 230 Parkway
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ralph — Middle: A. — Last: Bartholomew

4. **DATE OF DEATH**: Month: April — Day: 25, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-16-12

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Specialist

10b. KIND OF BUSINESS OR INDUSTRY: U S Government

11. BIRTHPLACE (County & State, or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Theodore R Bartholomew

14. MOTHER'S MAIDEN NAME: Anna E Dross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Doris L. Bartholomew Greenbelt, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Bilateral Pulmonary congestion — INTERVAL BETWEEN ONSET AND DEATH: 1/2hr.
DUE TO (b): Arterisclerotic Heart Disease + Coronary Thrombosis — 10-12 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Cardiac Failure — 6wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 25, 1962, to April 25, 19 62 that (I) (we) last saw the deceased alive on April 25, 62 and that death occured at 9:45 P.M. the causes and on the date stated above.

22a. SIGNATURE: Albert Roth M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Albert Roth.

22d. ADDRESS: 5510 Madison St., Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transportation

23b. DATE THEREOF: 4/26/62

23c. NAME OF CEMETERY OR CREMATORY: Centerville

23d. LOCATION (City, town or county) (State): Iowa

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04871

FOR STATE HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X District Heights
   d. STREET ADDRESS: 1 8 Delano Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3. **NAME OF DECEASED** (Type or print): First: William — Middle: John — Last: Bartz Sr.

4. **DATE OF DEATH**: Month: April — Day: 8th., — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒X — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Aug. 26, 1912

9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tile setter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William Frederick Bartz

14. MOTHER'S MAIDEN NAME: Catherine Sagorski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 579-18-7052

17. INFORMANT — Address: Irene Ethel Bartz, same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 442X Acute congestive heart failure
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒X

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒X, Inquiry ☒X, and in my opinion death resulted from: Natural causes ☒X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒X

Address (Street, city, town, or county)

DATE SIGNED: 4/8/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 11-62

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

22d. LOCATION (City, town, or country) (State): Bladensburg Md

23. FUNERAL DIRECTOR: Simmons Bros. — ADDRESS: 1661- Good Hope Rd SE WASH 20 DC

24a. REC'D BY REGISTRAR — DATE: APR 11 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04873

CERTIFICATE OF DEATH

04872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 7 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 38 Hyattsville
   d. STREET ADDRESS: 6703 Redfield Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Dorothy — Middle: I. — Last: Beaver

4. **DATE OF DEATH**: Month: April — Day: 30 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-24-83

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Washington D C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Claude Marion

14. MOTHER'S MAIDEN NAME: Marinda Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or detes of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address: Cheverly Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (e): Necrosis of left cerebellar hemisphere — INTERVAL BETWEEN ONSET AND DEATH: 1 week

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral Arteriosclerosis — years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-23, 19 62 to 4-30, 19 62 that (I) (we) last saw the deceased alive on 4-30 19 62, and that death occured at 9:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Hei K. Lee M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Hei Kit Lee

22d. ADDRESS: 7730 Annapolis Rodd, Lanham, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 2, 1962

23c. NAME OF CEMETERY OR CREMATORY: U S Soldiers Home Cemetery

23d. LOCATION (City, town or county) (State): Washington D C

24 FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville Md.

25a. REC'D BY REGISTRAR DATE: MAY 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Riana

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04874 — 04873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 27 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Hyattsville
   d. STREET ADDRESS: 6100 Ager Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Eugene — Middle: E. — Last: Behrend

4. **DATE OF DEATH**: Month: April — Day: 26 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-7-78

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Mfgd. of jewelry

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Uriha Behrend

14. MOTHER'S MAIDEN NAME: Frances Etting

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 579-54-7889

17. INFORMANT — Address: J. Norman Ager - 6100 Ager Rd., W. Hyattsville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Pyelonephritis with Uremia
DUE TO (b): Perforated gastric ulcer, post-surgical status
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 27 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/30, 1962, to 4/26, 1962, that (I) (we) last saw the deceased alive on 4/26, 1962, and that death occured at 11:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: David S Clayman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/26/62

22c. PHYSICIAN'S NAME (Type): Dr. David S. Clayman

22d. ADDRESS: 6311 Baltimore Ave., Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-30-62

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A Zieka — ADDRESS: 8434 Georgia Ave

Warner E. Pumphrey, Inc., Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04875

CERTIFICATE OF DEATH

Reg. Dist. No. 04874

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OXON HILL
c. LENGTH OF STAY IN 1b: 10 years.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6313 - Livingston Rd. S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 OXON HILL
d. STREET ADDRESS: 6313 - LIVINGSTON Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BENJAMIN Middle BRISCOE Last BELL

4. DATE OF DEATH: Month APRIL Day 2 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY. 1. 1893

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CUSTODIAN

10b. KIND OF BUSINESS OR INDUSTRY: SCHOOL (Md)

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: CHARLES DAVID BELL

14. MOTHER'S MAIDEN NAME: Clara W. STEPHENS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 579-03-2825

17. INFORMANT: Clarence M. BELL (Brother) Address: WARSAW, VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA of LUNGS.
163X
DUE TO (b): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

INTERVAL BETWEEN ONSET AND DEATH: 1½ years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1962, to APRIL, 1962, that I last saw the deceased alive on MARCH. 31, 1962, and that death occurred at 7:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Max E Feldman M.D. M.D.
ADDRESS (Street, city or town, state): 3800 S. Capitol St. Wash. 20 D.C.
DATE SIGNED: 4/2/62

PHYSICIAN'S NAME (Type): MAX E. FELDMAN M.D. Maryland Registration No. A 3874

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 4-62
22c. NAME OF CEMETERY OR CREMATORY: Beulah Bap church
22d. LOCATION (City, town, or county) (State): Warsaw, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros
ADDRESS: 1661 - Gd Hope Rd

24a. REC'D BY REGISTRAR DATE: APR 5 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

mail DC

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04876

CERTIFICATE OF DEATH

04875

1

M

77

I

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. Washington, D. C. — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 20 Suitland, Maryland
d. STREET ADDRESS: 4706 Homer Ave., S. E. (Suitland)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: — Last: Bellavin

4. DATE OF DEATH: Month: April — Day: 26 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-16-82

9. AGE (In years last birthday): XXX79 Yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): XXXX Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ignatius Lubo

14. MOTHER'S MAIDEN NAME: Anna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Nicholas P. Bellavin — Address: Same as # 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized peritonitis
153.3
DUE TO (b): Multiple perforations of descending colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Intestinal Obstruction
Carcinoma of the Sigmoid Colon

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/18, 19 62 to 4/26, 19 62 that (I) (we) last saw the deceased alive on 4/26 19 62, and that death occured at 11:05, from the causes and on the date stated above.

22a. SIGNATURE: Hei K. Lee M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: A.M.

22c. PHYSICIAN'S NAME (Type): Dr. Hei Kit Lee

22d. ADDRESS: 7730 Annapolis Rd., Lanham, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: may 1 - 62

23c. NAME OF CEMETERY OR CREMATORY: Washington National

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Simmons Bros 166 Good Hope

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04877 04876

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): 62 Hyattsville
d. STREET ADDRESS: 6007 41st Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis; Middle: B.F.; Last: Benton
4. DATE OF DEATH: Month: April; Day: 17; Year: 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 17, 1913
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick Benton
14. MOTHER'S MAIDEN NAME: Anna Lipska
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 505 10 16 76
17. INFORMANT: Mrs Bonnie C. Benton — Address: Wife as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/16, 1962, to 4/17, 1962, that (I) (we) last saw the deceased alive on 4/16, 1962, and that death occurred at 6:45 A.M. the causes and on the date stated above.

22a. SIGNATURE: Max M. Herzberg — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: April 17, '62
22c. PHYSICIAN'S NAME (Type): Dr. M. Herzberg
22d. ADDRESS: 7016 Greig St., Seat Pleasant, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/20/1962
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Colmarmanor Md.
24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Lee Funeral Home 300 4th. St. N.E. J.W. Lee Wash. D.C.
25a. REC'D BY REGISTRAR DATE APR 23 '62
25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
SM 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04877

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
c. LENGTH OF STAY IN 1b: 23 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 347 Cipriano Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 67 Lanham
d. STREET ADDRESS: 347 Cipriano Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Eugene — Last: Berger

4. DATE OF DEATH: Month: April — Day: 1 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 28, 1899 62 yrs.

9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cab Driver

10b. KIND OF BUSINESS OR INDUSTRY: Transportation

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown Robert Berger

14. MOTHER'S MAIDEN NAME: Unknown - Lola Frye

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — WW 1

16. SOCIAL SECURITY NO.: 578 24 4278

17. INFORMANT — Address: Virginia Davis Berger, same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary arteriosclerotic heart disease
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/1/62
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Spacify): Burial
22b. DATE THEREOF: 4/4/62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.
22d. LOCATION (City, town, or country) (State): Bladensburgh Maryland

23. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers Co. Riverdale, Md.

24a. REC'D BY REGISTRAR — DATE: APR 3 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

1
FOR STATE HEALTH DEPT.

M

X

I

0

2

8

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04879

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04878

1. PLACE OF DEATH
a. COUNTY: Prince George County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Capitol Heights
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 420 - 57th. Avenue

2. USUAL RESIDENCE (Where deceased livad, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Capitol Heights
d. STREET ADDRESS: 420 - 57th. Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George; Middle: Washington; Last: Blake

4. DATE OF DEATH: Month: April; Day: 23; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 27, 1897

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Blake

14. MOTHER'S MAIDEN NAME: Ida Elizabeth Lovejoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 220-03-4075

17. INFORMANT: Mrs. Dora Barnett; Address: 6133 Shadyside Ave. Capitol Hgts., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b): Coronary artery Disease (Arteriosclerotic) — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): General Arteriosclerosis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Bronchial Asthma (Emphysema)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Natural Causes

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Paul C VanNatta M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. Paul C. VanNatta

Address (Street, city, town, or county):

DATE SIGNED: April 23.1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/27-1962

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or country) (State): Suitland, Md.

23. FUNERAL DIRECTOR: W. W. Chambers Co — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR: DATE APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04880

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04879

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Seat Pleasant
d. STREET ADDRESS: 7410 F Street, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Doris — Middle: Evelyn — Last: Blankenship

4. DATE OF DEATH: Month: April — Day: 5th, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ XX WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 2, 1954

9. AGE (If years last birthday): 8 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Blankenship

14. MOTHER'S MAIDEN NAME: Pauline Virginia Abbott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Pauline V. Abbott — Address: 7410 F St., N.E., Seat Pleasant, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Contusions of Brain — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Skating in the street when stuck by automobile

20c. TIME OF INJURY: Hour XX p.m. 5:15 — Month, Day, Year: 3/24 1962

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or Town) (County) (State): Carmondy Hills, P.G., Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/5/62

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 10, 1962

22c. NAME OF CEMETERY: Mud Fork Cemetery

22d. LOCATION (City, town, or country) (State): Mud Fork, Logan Cty. W.Va.

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO.

ADDRESS: Riverdale, Maryland

24a. REC'D BY REGISTRAR: APR 11 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Miller

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04881 04880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Riverdale
   c. LENGTH OF STAY IN 1b: 30 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Leland Memorial Hosp

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 65 Riverdale
   d. STREET ADDRESS: 4708 Oglethorpe St
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: John — Middle: W — Last: Boland

4. **DATE OF DEATH**: Month: April — Day: 9 — Year: 1962

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-31-'80

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-U.S.Govt.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Edward Boland

14. MOTHER'S MAIDEN NAME: Phoebe Jennie Paxton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): Spanish -Amr.

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hospital Record

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

332X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gadgets disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-9 19[illegible], to 4-9 19[illegible], that (I) (we) last saw the deceased alive on 4-9 19[illegible], and that death occured at 4:[illegible] AM, from the causes and on the date stated above.

22e. SIGNATURE: D. R. Randle M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/13/62

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons

ADDRESS: Hyattsville, Maryland

25a. REC'D BY REGISTRAR DATE: APR 12 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

APR 12 '62

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04882

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04881

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George Gen.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 74 Beltsville
d. STREET ADDRESS: 12424-Old Gun Power Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Regina; Middle: Marie; Last: Bowen

4. DATE OF DEATH: Month: April; Day: 22; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 10, 1962

9. AGE (In years last birthday): yrs. 2 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Montgomery Co. Md.

12. CITIZEN OF WHAT COUNTRY? yes USA

13. FATHER'S NAME: Charles L. Bowen

14. MOTHER'S MAIDEN NAME: Ester Marie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT — Address: Charles L. Bowen - Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Paul C Van Natta M.D.

EXAMINER'S NAME (Type): Paul C. Van Natta acting

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county):

DATE SIGNED: 4/22/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/24/62

22c. NAME OF CEMETERY OR CREMATORY: Derwood Cemetery

22d. LOCATION (City, town, or country) (State): Derwood, Maryland

23. FUNERAL DIRECTOR — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

24a. REC'D BY REGISTRAR — DATE: APR 26 '62

24b. REGISTRAR'S SIGNATURE: Clinton L. Peterson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/62

2-052223

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04883

CERTIFICATE OF DEATH

04882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town): Riverdale
   c. LENGTH OF STAY IN 1b: 2 days.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Leland Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 70 Berwyn, Hghts, Md.
   d. STREET ADDRESS: 9112 Baltimore Ave,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mock — Middle: Eliza — Last: Boyle

4. **DATE OF DEATH**: Month: April — Day: 28 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUG 16, 1882

9. AGE (In years last birthday): 79 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Fitzhugh

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hosp. Record

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	2 days
DUE TO (b)	Congestive heart failure	? 1 month
DUE TO (c)	Malnutrition and dehydration	? 1 month

286.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-26, 1962 to 4-28, 1962 that (I) (we) last saw the deceased alive on 4-28 1962, and that death occured at 6:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ronald E Krum M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-28-62

22c. PHYSICIAN'S NAME (Type): Ronald E Krum

22d. ADDRESS: Leland Mem Hospital, Riverdale, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-1-1962

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.

23d. LOCATION (City, town or county) (State): Bladensburg, Maryland.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. W. Chambers Co.; Riverdale, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 2 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04884

CERTIFICATE OF DEATH

04883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 12 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 69 College Park
   d. STREET ADDRESS: 5010 Luguna Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Charles — Middle: A. — Last: Bradley

4. **DATE OF DEATH**: Month: April — Day: 2 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-15-11

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ass't Director of Personnel, N.L.R.B.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Wash. D. C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: George E. Bradley,

14. MOTHER'S MAIDEN NAME: Katherine B. Bradley,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Dorothy A. Bradley, wife,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

(a) IMMEDIATE CAUSE: Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(b) Porto-Caval Anastomosis (3 days post-operative)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c) Cirrhosis of the Liver with bleeding esophageal varices unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec., 1961, to 4-2-62, 19..., that (I) (we) last saw the deceased alive on 4-2-62, 19..., and that death occured at 11:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: William C. Weintraub M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Dr. William C. Weintraub

22d. ADDRESS: 9 E Parkway Rd., Greenbelt, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/5/62

23c. NAME OF CEMETERY OR CREMATORY: Arlington Cem.

23d. LOCATION (City, town or county): Arlington (State): Va

24 FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon — ADDRESS: 4748 Wisc Ave.

25a. REC'D BY REGISTRAR DATE: APR 9 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Rhame

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04885

CERTIFICATE OF DEATH

04884

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince George' — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 3 months
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbelt
   d. STREET ADDRESS: 10 U Southway
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Pauline — Middle: C. — Last: Brandenburg

4. **DATE OF DEATH**: Month: April — Day: 30 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-20-25

9. AGE (In years last birthday): 36 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James C. Monahan

14. MOTHER'S MAIDEN NAME: Clara Baxter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Nevin G. Brandenburg same as #2 (Husband)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 4

518 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Empyema — 3 months

DUE TO (c): & Encephalopathy - etiology undetermined — 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 5, 19 62 to April 30, 19 62, that (I) (we) last saw the deceased alive on April 30, 19 62, and that death occured at 11:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Wm C. Weintraub M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. William C. Weintraub

22d. ADDRESS: 9 E Parkway Rd., Greenbelt, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/3/62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

23d. LOCATION (City, town or county) (State): Frederick, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons

ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04886 04885

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Run Hills
c. LENGTH OF STAY IN 1b: 18- Months
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: 4913 - 28th Parkway S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: Maryland b. COUNTY: Pr. Goe's Co.
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): 18 Oxon Run Hills
d. STREET ADDRESS: 1 4913 - 28th Parkway S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle A. Last BRENNAN

4. DATE OF DEATH: Month April Day 12th Year 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 10- 1878

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Parkhill

14. MOTHER'S MAIDEN NAME: Mary J. McCarthy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Helene C. Masterson Address: Same as # 2. Dau.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 15 yr

DUE TO (b): Hypertension — 15 yr

DUE TO (c):

443X

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from March 13, 1961, to April 12, 1962 that (I) (~~we~~) last saw the deceased alive on April 12 1962, and that death occurred at 4P M, from the causes and on the date stated above.

22a. SIGNATURE: James C. Cawood M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 12, 1962

22c. PHYSICIAN'S NAME (Type): James C. Cawood

22d. ADDRESS: 2520 Pa Ave S.E. Washington 20, DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 16- 62

23c. NAME OF CEMETERY OR CREMATORY: St. Bonaventure Cemetery

23d. LOCATION (City, town, or county) (State): Olean, New York

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Brothers

ADDRESS: 1661 Good Hope Road SE Washington 20, DC.

25a. REC'D BY REGISTRAR DATE APR 16 '62

25b. REGISTRAR'S SIGNATURE: Clinton L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

99

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04887 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04886

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 36 Carrollton
d. STREET ADDRESS: 5908 85th., Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wayne — Middle: David — Last: Brinkley

4. DATE OF DEATH: Month: April — Day: 26, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 3, 1957

9. AGE (In years last birthday): 5 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Halliard Brinkley

14. MOTHER'S MAIDEN NAME: Doris Mae Yingling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ernest Halliard Brinkley — Address: 5908 85th. Ave., Carrollton Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 231X RESPIRATORY OBSTRUCTION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): COMPRESSION OF TRACHEA
DUE TO (c): TUMOR OF MEDIASTINUM

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul C Van Natta M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/26/62

EXAMINER'S NAME (Type): Paul C. Van Natta, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 28-1962

22c. NAME OF CEMETERY OR CREMATORY: Whitfield

22d. LOCATION (City, town, or county): Lanham Md (State)

23. FUNERAL DIRECTOR: F Bosche Sons — ADDRESS: Hyattsville Md

24a. REC'D BY REGISTRAR: DATE APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04888

CERTIFICATE OF DEATH

04887

Information from birth cert.

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 1day
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Calvert
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North Beach 04X-2
   d. STREET ADDRESS: General Del.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Baby — Middle: Boy — Last: Britt

4. **DATE OF DEATH**: Month: April — Day: 7 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6 April 1962

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours: 24 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter Lafayette Britt

14. MOTHER'S MAIDEN NAME: Margaret Grace McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1. Bilateral Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH
754.5
DUE TO (b): 2. Congenital Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

2De. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY: Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6 Apr, 19 62 to 7 Apr, 19 62, that (I) (we) last saw the deceased alive on 7 Apr 1962, and that death occured at 10 PM, from the causes and on the date stated above.

22e. SIGNATURE: R R Sasscer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. R. Sasscer., M.D.

22d. ADDRESS: Upper Marlboro., Md

23e. BURIAL, CREMATION, REMOVAL, (Specify): Cremation

23b. DATE THEREOF: 4-13-62

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Administrator

ADDRESS

25a. REC'D BY REGISTRAR DATE: APR 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2-046048

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04889 Item 23 Film 0312 5/1/62 mh 04888

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
c. LENGTH OF STAY IN 1b: 4 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF Hospital Andrews

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2243 Chester St SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY BOY Middle: Last: Brown

4. DATE OF DEATH: Month: April Day: 25 Year: 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 25 April 62

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 4 Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Prince Georges, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Brown

14. MOTHER'S MAIDEN NAME: Mabel R. Tabb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unkown): No

16. SOCIAL SECURITY NO. (If yes give wer or dates of service): None

17. INFORMANT Address: Hospital Chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs
DUE TO (b): Prematurity — 4 hrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7 7 6 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 25 April, 1962 to 25 April, 1962 that (✱) (we) last saw the deceased alive on 25 April 1962 and that death occured at 2:39 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Nicholas P. Haritos M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 25 April 62

22c. PHYSICIAN'S NAME (Type): NICHOLAS P HARITOS, Capt USAF MC

22d. ADDRESS: USAF HOSP, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremated

23b. DATE THEREOF: April 26, 1962

23c. NAME OF CEMETERY OR CREMATORY: DC Morgue

23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS

25a. REC'D BY REGISTRAR DATE APR 27 '62

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

2-068277

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04890

CERTIFICATE OF DEATH

04889

1. **PLACE OF DEATH** a. COUNTY: Prince George's County — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: PG
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X
d. STREET ADDRESS: Hill Road, Landover, Md.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Bernard — Middle: F — Last: Brown

4. DATE OF DEATH: Month: 4 — Day: 5 — Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 10-1-73

9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Landover Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richard Brown

14. MOTHER'S MAIDEN NAME: Mildred J. Grabitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs Bessie Brown - same as above.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1. Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO (b) 2. Cerebral arteriosclerosis
DUE TO (c) 3. Diabetes mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 19 57 to 4-5- 1962 that (I) (we) last saw the deceased alive on 4-5 19 62 and that death occured at 9:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Peter Duus M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Peter Duus

22d. ADDRESS: 6124 Central Ave., Capitol Hgts., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-8-62

23c. NAME OF CEMETERY OR CREMATORY: Addison Chapel

23d. LOCATION (City, town or county) (State): Seat Pleasant, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. W. Lees ADDRESS: Wash. D.C.

25a. REC'D BY REGISTRAR DATE: APR 11 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04891

CERTIFICATE OF DEATH

04890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kyattsville
c. LENGTH OF STAY IN 1b: 4½ mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Manor, 4922 La Salle Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 9, D.C.
d. STREET ADDRESS: 1629 Columbia Rd., N.W.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Kent — Last: Brown

4. DATE OF DEATH: Month: April — Day: 20 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 4, 1888

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (County & State, or foreign country): Lincoln, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Miles Bainbridge King

14. MOTHER'S MAIDEN NAME: Clara Kent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Clyde G. Brown (Husband) Address: 1629 Col. Rd.,N.W. Wash 9 D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — 9 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (his/her/~~mmmmm~~) (official) attended the deceased from Nov. 13, 1957 to April 20, 1962 that (I) (~~mm~~) last saw the deceased alive on April 16, 1962, and that death occured at 12:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: George Dewey M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/20/62

22c. PHYSICIAN'S NAME (Type): George Dewey, M.D.

22d. ADDRESS: 1629 Columbia Rd.,N.W., Washington 9, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 4-21-62

23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

23d. LOCATION (City, town or county) (State): SUITLAND Md.

24 FUNERAL DIRECTOR'S SIGNATURE: JOSEPH GAWLER'S SONS, INC.
ADDRESS: 1756 PENN. AVE. N.W. WASHINGTON 6, D.C.

25a. REC'D BY REGISTRAR DATE: APR 23 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04832

CERTIFICATE OF DEATH

04891

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: Em. Room
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 District Heights
d. STREET ADDRESS: 7800 District Hghts., Pkwy.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: M. — Last: Bruce

4. DATE OF DEATH: Month: April — Day: 10 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 11-12-27

9. AGE (In years last birthday): 34 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: August Heimbuch

14. MOTHER'S MAIDEN NAME: Kathryn Comfort

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: 214-24-8907

17. INFORMANT Address: Kathryn Heimbuch 8139 Old Phila. Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heartfailure
DUE TO (b): Complete Heartblock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Rheumatic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 15, 1961 to April 8, 1962, that (I) (we) last saw the deceased alive on April 8 1962, and that death occured at 11:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Max M. Herzberg M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/11/62

22c. PHYSICIAN'S NAME (Type): Dr. M. M. Herzberg

22d. ADDRESS: 7016 Greigg Street, Seat Pleasant, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-14-62

23c. NAME OF CEMETERY ~~OR CREMATORY~~: Gardens of Faith

23d. LOCATION (City, town or county) (State): Baltimore Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Enoch Rosedale Md. Jr.

ADDRESS: 1211 Chesaco Ave.

25a. REC'D BY REGISTRAR DATE: APR 17 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04893 04892

1 M 76 1 0 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 7/61

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 1 hr 10 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 61 Hyattsville
d. STREET ADDRESS: 4018 Hamilton St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: August — Middle: Eugene — Last: Burgess

4. DATE OF DEATH: Month: April — Day: 27 — Year: 1962

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-18-88

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Merchant

11. BIRTHPLACE (County & State, or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Herman E. Burgess

14. MOTHER'S MAIDEN NAME: Katherine E. Grimm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Nephritis chronic glom. — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
5927
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 1, 1962 to Apr 27, 1962, that (I) (we) last saw the deceased alive on 4-~~Dec~~ 27, 1962, and that death occured at 0.?.M, from the causes and on the date stated above.

22a. SIGNATURE: Leonard Hays — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-27-62

22c. PHYSICIAN'S NAME (Type): LEONARD HAYS

22d. ADDRESS: Hyattsville, Md 4/27/62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 1, 1962

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln

23d. LOCATION (City, town or county) (State): Colmar Manor Md

24 FUNERAL DIRECTOR'S SIGNATURE: F Gasch & Sons — ADDRESS: Hyattsville, Md

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04894 (04893)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 20
   d. STREET ADDRESS: D-1 Cypress Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Carl — Middle: J — Last: Cain

4. **DATE OF DEATH**: Month: April — Day: 29 — Year: 19 62

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/21/1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Internal Rev. Ser.

11. BIRTHPLACE (County & State, or foreign country): NEBRASKA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Cain

14. MOTHER'S MAIDEN NAME: Sarah Winkler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 359-07-2279

17. INFORMANT — Address: Mrs. Loretta Cain, D-1, Cypress Drive, ZONE 20

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e): Encephalomalacia (Whole Left Brain) — INTERVAL BETWEEN ONSET AND DEATH

434.4

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO (b): Arteriosclerosis Heart Disease

DUE TO (c): L/Ventricle Hypertrophy

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/22, 1962 to 4/29, 19 62 that (I) (we) last saw the deceased alive on 4/29 19 62 and that death occured at 2:10 p.M, from the causes and on the date stated above.

22a. SIGNATURE: Hei K. Lee M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): HEI K. LEE

22d. ADDRESS: 7732 Annapolis Rd. LANHAM, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-4-62

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town or county) (State): Baltimore

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: WILLIAM COOK, INC., 1217 St. Paul Street, ZONE 2

25a. REC'D BY REGISTRAR — DATE MAY 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04895

CERTIFICATE OF DEATH

04894

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural (Glenn Dale)
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale, Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
e. STATE: District of Columbia
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X3
d. STREET ADDRESS: 1348 C Street, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First DAVID — Middle - — Last CALDWELL

4. **DATE OF DEATH**: Month April — Day 28 — Year 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Legally separated

8. DATE OF BIRTH: December 25, 1910

9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafeteria Helper

10b. KIND OF BUSINESS OR INDUSTRY: Eastern High School

11. BIRTHPLACE (County & State, or foreign country): Lawrence, S.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Caldwell

14. MOTHER'S MAIDEN NAME: Carrie French

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): unknown -

16. SOCIAL SECURITY NO.: 577-14-5161

17. INFORMANT: Person — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Pulmonary Tuberculosis — 2 yrs., 4 mo
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/4, 19 60 to 4/28, 1962, that (I) (we) last saw the deceased alive on 4/28 1962, and that death occured at 12:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 4/28/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-2-62

23c. NAME OF CEMETERY OR CREMATORY: HARMONY MEM'L. PK

23d. LOCATION (City, town or county) (State): 7601 SHERIFF RD, N.E. MD.

24 FUNERAL DIRECTOR'S SIGNATURE: HOFFMAN FUN'L HOME B.F.S.

ADDRESS: 909 6TH ST, NW - D.C.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Reams

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04896 Item 9 Film G312 5/1/62 mh 04895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hyattsville, Md.
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 2022 Lewisdale Drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 58 Hyattsville, Md
d. STREET ADDRESS: 2022 Lewisdale Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lulu — Middle: Gertrude — Last: Cowles

4. DATE OF DEATH: Month: April — Day: 23 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 8, 1884

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Hartford, Conn.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Hosea Potter

14. MOTHER'S MAIDEN NAME: Josephine Aldenhofen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Alden Cowles — Address: 2022 Lewisdale Dr. Hyattsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO (b): Carcinoma of rectum
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

154X

INTERVAL BETWEEN ONSET AND DEATH: 1½ years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Feb. 26, 1962 to April 23, 1962 that (I) (~~me~~) last saw the deceased alive on April 23 1962, and that death occured at 1:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Norman H. Rubenstein M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/23/62

22c. PHYSICIAN'S NAME (Type): NORMAN H. RUBENSTEIN

22d. ADDRESS: 6480 N.H. Ave. Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL: (Specify): Burial

23b. DATE THEREOF: Apr 5, 1962

23c. NAME OF CEMETERY OR ~~XXXXXXX~~: Spring Grove

23d. LOCATION (City, town or county) (State): Hartford Connecticut

24 FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: APR 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04897 04896

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Oxen Hill
d. STREET ADDRESS: 5580 Spur Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Curtin

4. DATE OF DEATH: Month: April — Day: 26 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 25 April 1962

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours: 12 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jackson Marshall

14. MOTHER'S MAIDEN NAME: Glenda Jean Lobaugh Curtin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Pulmonary Atectasis — INTERVAL BETWEEN ONSET AND DEATH: hrs
771.0
DUE TO (b): Bilateral Adrenal Hemorrohage — hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): — hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yaer 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/25, 1962, to 4/26, 19.62 that (I) (we) last saw the deceased alive on 4/26, 19.62, and that death occured at 5,40A M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph J. McDonald M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4/26/62

22c. PHYSICIAN'S NAME (Type): Dr. Joseph J. McDonald

22d. ADDRESS: 7309 Riggs Rd., W. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: May 5, 1962

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Administrator — ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2.046547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04898 (upper left) 04897 (upper right)

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 2½ days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 District Heights
   d. STREET ADDRESS: 724 - 60th Place
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Baby Girl "A" — Middle: — Last: Deale

4. **DATE OF DEATH**: Month: April — Day: 25 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 23, 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: 2 — IF UNDER 24 HRS.: Hours: 8 — Min.: 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: [illegible] Wheeler Kellibrew

14. MOTHER'S MAIDEN NAME: Yvonne Deale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	life
7605 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b)	Bilateral Pulmonary Atelectasis	life
DUE TO (c)	Prematurity	life

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/23, 1962 to 4/25, 1962, that (I) (we) last saw the deceased alive on 4/25, 1962, and that death occured at 5:28 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph McDonald M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑ — 22b. DATE SIGNED: 4/26/62

22c. PHYSICIAN'S NAME (Type): Dr. Joseph J. McDonald

22d. ADDRESS: 7309 Riggs Rd., W. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 5 May 1962

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Sr., Administrator — ADDRESS:

25a. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Civilian S. Krauss

2-046540

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04899 04898

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 District Heights
d. STREET ADDRESS: 1 724-60th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Girl ("B") Middle: Last: Deale

4. DATE OF DEATH: Month: April Day: 30 Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4-23-62

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months: Days: 7 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Wheeler Kellibrew

14. MOTHER'S MAIDEN NAME: Yvonne Deale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/23, 1962, to 4/30, 19.62 that (I) (we) last saw the deceased alive on 4/30, 19 62, and that death occured 2:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Salvatore Battiata M.D.

22b. DATE SIGNED:

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Dr. Salvatore Battiata

22d. ADDRESS: 7309 Riggs Rd., Hyattsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 5-8-62

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Harry W. Peen, Jr., Administrator

25a. REC'D BY REGISTRAR DATE MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2-046538

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04900 Reg. Dist. No. 04899

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
c. LENGTH OF STAY IN 1b ?
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION 2418 Kirston Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5814 Hyattsville
d. STREET ADDRESS 2418 Kirston Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lucille Middle J. Last Dennis

4. DATE OF DEATH Month 4 Day 24 Year 1962

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct 2, 1921
9. AGE (In years last birthday) 40 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME HARRY W. ROSIE
14. MOTHER'S MAIDEN NAME MAUDE BARNES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
INFORMANT John H. Dennis Jr. Address above Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Collapse — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b) Leiomyosarcoma Inferior Vena Cava — 2 yrs
DUE TO (c) ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1979

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 1961, to 4-24, 1962, that I last saw the deceased alive on 4-24, 1962, and that death occurred at 5:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Jerome H. Epstein M.D.
ADDRESS (Street, city or town, state) 2025 EYE ST, NW
DATE SIGNED
PHYSICIAN'S NAME (Type) JEROME H. EPSTEIN, MD WASH 6, DC

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4/27/62
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State) Suitland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.
ADDRESS Mt. Rainier Md.
24a. REC'D BY REGISTRAR DATE APR 30 '62
24b. REGISTRAR'S SIGNATURE Clarence E. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04901 — Reg. Dist. No. 04300

1. PLACE OF DEATH
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): University Hills
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3415 Stanford Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 59 University Hills
d. STREET ADDRESS: 3415 Stanford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THEODORE — Middle W — Last DENT

4. DATE OF DEATH: Month April — Day 15, — Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-9-1900

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant (Retd)

10b. KIND OF BUSINESS OR INDUSTRY: Clerical

11. BIRTHPLACE (State or foreign country): DRAYDEN [illegible], Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W Dent

14. MOTHER'S MAIDEN NAME: Mary G Coulbourn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-36-8062

17. INFORMANT: Beatrice Jones Dent — Address: 3415 Stanford St University Hills Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Larynx — INTERVAL BETWEEN ONSET AND DEATH: 6-15-61
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-15-61, 19____, to 4-15, 19 62 that I last saw the deceased alive on 4-15-62, 19____, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John P. Clum M.D. — ADDRESS (Street, city or town, state): Hyattsville Md — DATE SIGNED: 4/16/62

PHYSICIAN'S NAME (Type): JOHN P. CLUM, M.D. — 6110 43rd Avenue, Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-18-62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem
22d. LOCATION (City, town, or county) (State): Bladensburg Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. W. CHAMBERS CO. Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: APR 18 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04902 04901

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 Oxen Hill
d. STREET ADDRESS: 6245 St. Barnabas Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herschel — Middle: Eugene — Last: Dishner, Jr

4. DATE OF DEATH: Month: April — Day: 18 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 11, 1956

9. AGE (In years last birthday): 6 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): California

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Herschel E. Dishner, Sr.

14. MOTHER'S MAIDEN NAME: Marguerite E. Behrens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Hospital Record

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	
DUE TO (b)	generalized peritonitis — toxic Heart	8
DUE TO (c)	Suppurative Gangrenous Appendicitis	8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 550.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-10, 19 62 to 4-18, 19 62 that (I) (we) last saw the deceased alive on 4-18 19 62 and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Rowland F. Wilkinson M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Rowland F. Wilkinson

22d. ADDRESS: 4408 Queensbury Road Riverdale, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-21-1962

23c. NAME OF CEMETERY OR CREMATORY: Nat'l Memorial Park

23d. LOCATION (City, town or county) (State): Falls Church, Va

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Mattingly

ADDRESS 131-11th St Washington DC

25a. REC'D BY REGISTRAR DATE APR 24 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thrane

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04903

CERTIFICATE OF DEATH

04902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Heights
c. LENGTH OF STAY IN 1b: 7 yrs
d. NAME OF HOSPITAL OR INSTITUTION: 340 Cree Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Heights
d. STREET ADDRESS: 340 Cree Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELIZA — Middle: AUGUSTA — Last: DOWNS

4. DATE OF DEATH: Month: April — Day: 29, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 23, 1887

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Sween

14. MOTHER'S MAIDEN NAME: Elizabeth Stevens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Howard F. Downs — Address: 1. a, b, c, above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): coronary atherosclerosis — unknown

DUE TO (c): general atherosclerosis — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 66 to April 29, 1962 that (I) (we) last saw the deceased alive on Apr 24, 1962, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Henry G. Hadley M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): HENRY G HADLEY MD

22d. ADDRESS: 4601 Nichols Ave SE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 2, 1962

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

23d. LOCATION (City, town, or county) (State): Bladensburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: James T. Ryan, Inc. per J.

ADDRESS: 317 Pa. Ave., SE Wash. 3, D.C.

25a. REC'D BY REGISTRAR DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04904 — 04903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: Prince George's County — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly, Md.
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 63 5213 Baltimore Ave., Hyattsville, Md.
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Wesley — Middle: W.AYNE — Last: Downs,Sr.

4. **DATE OF DEATH**: Month: 4 — Day: 17 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 7-15-1901

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Transportation Specialist

10b. KIND OF BUSINESS OR INDUSTRY: Dept of Army

11. BIRTHPLACE (County & State, or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Wesley Wayne Downs, Jr. — Address: Same as # 2

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH:
260X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis Heart Disease
DUE TO (c): Diabitus Mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 16, 1962, to April 17, 1962., that (I) (we) last saw the deceased alive on April 17 19 62, and that death occured at 4:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Peter Duus M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: April 18, 1962

22c. PHYSICIAN'S NAME (Type): Dr. Peter Duus

22d. ADDRESS: 6124 Central Avenue, Capitol Heights, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-21-62

23c. NAME OF CEMETERY OR CREMATORY: Washington National

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co.

ADDRESS: Lewisdale, Md.

25a. REC'D BY REGISTRAR — DATE: APR 24 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Krause

VR AIS (4)
1SM 7/61

FOR STATE HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04905

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04904

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 18 Hillcrest Heights
d. STREET ADDRESS: 5776 26th., Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julitis — Middle: Klor — Last: Draheim

4. DATE OF DEATH: Month: April — Day: 30, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 30, 1916

9. AGE (If years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ass't Machinist

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): Indianna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Julitis Draheim

14. MOTHER'S MAIDEN NAME: Adeline Stallman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give wer or dates of service): W.W. 11

16. SOCIAL SECURITY NO.: 578-09-5679

17. INFORMANT: Rose Draheim — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b): Coronary Vascular disease — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): natural causes

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Paul C Van Natta M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/30/62

EXAMINER'S NAME (Type): PAUL C. VAN NATTA, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 3-62

22c. NAME OF CEMETERY OR CREMATORY: Arlington natl.

22d. LOCATION (City, town, or country) (State): Arlington Va.

23. FUNERAL DIRECTOR: Semmons Bros. Funeral Home
ADDRESS: 1661- Good Hope Rd SE Wash 20 DC

24a. REC'D BY REGISTRAR DATE: MAY 3 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04906

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04905

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME SM 1/62

1. PLACE OF DEATH
   a. COUNTY: Prince George's
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 69 College Park
   d. STREET ADDRESS: 9719 53rd. Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: Ernest; Last: Dube

4. DATE OF DEATH: Month: April; Day: 5th.; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 11, 1917

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months: ; Days:

IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman Maintainence

10b. KIND OF BUSINESS OR INDUSTRY: W.S.S.C.

11. BIRTHPLACE (State or foreign country): Exter, New Hampshire

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Cleophus Dube

14. MOTHER'S MAIDEN NAME: Anna St. Jean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes

(If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 003-01-9698

17. INFORMANT: Address 9719 53rd Ave., Mrs. Louise E. Dube, College Park, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 4209 Myocardial Infarction

DUE TO (b): Coronary Artery Thrombosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 4/5/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 9,1962

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO.

ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR: DATE APR 11 '62

24b. REGISTRAR'S SIGNATURE: Cathleen S. Krause

Items 20&21 Film 311 [illegible]

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04907 04906

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beverly
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Upper Marlboro
d. STREET ADDRESS: P.O. Box 3303
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Stephen — Middle: HURLEY — Last: Duck

4. DATE OF DEATH: Month: April — Day: 3 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: SEPT 21 -1886

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Painting, House.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: William Henry Dale — Address: 3992 81st Ave Forestville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture of right hip

9000 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b):

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiovascular renal disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell down stairs

20c. TIME OF INJURY: 8:00 Hour a.m. p.m. — Month, Day, Year: 2-2 19 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Upper Marlboro, P.G., Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): Dr. James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

DATE SIGNED: 4-3-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-7-1962

22c. NAME OF CEMETERY OR CREMATORY: Washington National

22d. LOCATION (City, town, or country) (State): Suitland, Maryland

23. FUNERAL DIRECTOR: W.W. Chambers Co — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: APR 6 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04908 04907

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

M

77

1

2

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Naylor
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joann — Middle: J. — Last: Duckett

4. DATE OF DEATH: Month: April — Day: 27, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday) ——yrs. IF UNDER 1 YEAR: Months: 2 Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Francis Duckett

14. MOTHER'S MAIDEN NAME: Matilda Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Matilda Gray - Brandywine, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Serious Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

491X

DUE TO (b): Upper Respiratory Infection — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None that I know

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Natural Causes

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year —— 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): None

20f. (City or town) (County) (State): —

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Paul C Van Natta M.D. — DATE SIGNED

EXAMINER'S NAME (Type): Paul C. Van Natta

Address (Street, city, town, or county): 5440 Silver Hill Rd., S.E Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/28/62

22c. NAME OF CEMETERY OR CREMATORY: Holynist Church

22d. LOCATION (City, town, or country) (State): Brandywine, Md.

23. FUNERAL DIRECTOR ADDRESS: George H. Kalmon Aquasco, Md

24a. REC'D BY REGISTRAR DATE: MAY 2 '62

24b. REGISTRAR'S SIGNATURE: Charles S. Runs

2-015388

1 FOR STATE HEALTH DEPT.

M 99

I

0

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04909 04908

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY: Camden
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Runnemeade 67X-3
d. STREET ADDRESS: #19 11th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DELLA Middle AMANDA Last DUNGAN

4. DATE OF DEATH: Month April Day 3 Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: October 3, 1887

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Candymaker

10b. KIND OF BUSINESS OR INDUSTRY: Candy

11. BIRTHPLACE (State or foreign country): Penns.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Ayers

14. MOTHER'S MAIDEN NAME: Amanda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wayne M. Milligan — Address: 9522 Washington Blvd. Seabrook, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Chronary occlusion	
DUE TO (b)	Coronary artery disease	
DUE TO (c)	Cardiovascular renal disease	

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes, obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): (State)

DATE SIGNED: 4/3/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 7, 1962

22c. NAME OF CEMETERY OR CREMATORY: Hillside Cemetery

22d. LOCATION (City, town, or country) (State): Roslyn Pa

23. FUNERAL DIRECTOR — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE APR 6 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1

FOR STATE HEALTH DEPT.

M

99

2

0

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04910

04909

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 13 Friendly
d. STREET ADDRESS: 8390 Old Fort Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice; Middle: ; Last: Edelin

4. DATE OF DEATH: April 8th., 1962

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: September 10,78

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Mary Brawner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Gertrude Blackman
723 Gresham Place NW
Washington, D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	442 Acute pulmonary Edema	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Congestive heart failure	
DUE TO		
(c)	Cardiovascular renal disease	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ **or CONTRIBUTING** ☐ **CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

Address (Street, city, town, or county):

DATE SIGNED: 4/8/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/12/62

22c. NAME OF CEMETERY OR CREMATORY: St. Philips Church

22d. LOCATION (City, town, or country) (State): Aquasco pr. G. Md

23. FUNERAL DIRECTOR: George S. Kelson

ADDRESS: Aquasco, Md

24a. REC'D BY REGISTRAR DATE: 4/9/62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

APR 16 '62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04911 04910

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 28 Seat Pleasent
d. STREET ADDRESS: 6113 St. Margaret Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOAN Baby Middle Louise Girl "B" Last Edwards

4. DATE OF DEATH: Month April Day 8 Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4 April 1962
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months Days X4 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant (none)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James L. Edwards
14. MOTHER'S MAIDEN NAME: Frances Louise Horman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiovasc. - Respiratory Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Prematurity
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-4 1962 to 4-8 -, 1962, that (I) (we) last saw the deceased alive on 4-7-1962 and that death occured at 7.06AM, from the causes and on the date stated above.

22a. SIGNATURE: Peter Duus M.D.
22b. DATE SIGNED: 4-8-62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): Dr. Peter Duus, M.D.
22d. ADDRESS: 6124 Central Ave., Capitol Heights, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-10-62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Linclon Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges, County, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis J. Coakley
ADDRESS: 3821-14th St. N.W.
25a. REC'D BY REGISTRAR DATE APR 11 '62
25b. REGISTRAR'S SIGNATURE

2-028385

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04912

CERTIFICATE OF DEATH

04911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: PrinceGeorges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 44 Cottage City
d. STREET ADDRESS: 3708 37th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Virginia — Middle: T — Last: Fell

4. **DATE OF DEATH**: April 29 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 19 Oct. 1889

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U S

10b. KIND OF BUSINESS OR INDUSTRY: Treasury

11. BIRTHPLACE (County & State, or foreign country): Washington D C

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Dalrymple

14. MOTHER'S MAIDEN NAME: Priscella Torbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Hospital records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): arteriosclerotic heart disease — 8 years

DUE TO (c): chronic congestive heart failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Healed rheumatic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 1 '61, 19 56, to April 29th, 1962, that (I) (we) last saw the deceased alive on April 26th 1962, and that death occured at 6.15 AM from the causes and on the date stated above.

22a. SIGNATURE: Till Bergemann M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/29/62

22c. PHYSICIAN'S NAME (Type): Dr. Till Bergemann, M.D.

22d. ADDRESS: 53 D Crescent Road Greenbelt Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 2, 1962

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 1 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

VR A15 (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

M

77

I

0

16

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04913

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04912

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL end give neerest town): X Mitchellsville
d. STREET ADDRESS: 1 Rt. 1 Box 68
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Shirley Mae Harley — Middle: — Last: Ford
4. DATE OF DEATH: Month: April — Dey: 24 — Yeer: 19 62

5. SEX: Female
6. COLOR OR RACE: Negro ~~Black~~
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 2-2-56
9. AGE (In yeers last birthdey): 6 yrs. — IF UNDER 1 YEAR: Months / Deys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ———
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Prince George Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis Proctor
14. MOTHER'S MAIDEN NAME: Elizabeth Harley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: *******
17. INFORMANT: Elizabeth Ford - Rt. 1 - Box 68 Mitchellville — Address: Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Toxemia Secondary Infections — INTERVAL BETWEEN ONSET AND DEATH: —
916.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Multiple and extensive Burns about body — 5 days
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): Clothes caught fire while Burning a Waste
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Yeer: 4/9/1962
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or Town) (County) (State): Mitchellville Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ]. Inspection [X]. Inquiry [ ]. and in my opinion death resulted from: Natural causes [ ]. Accident [X]. Suicide [ ]. Homicide [ ]. Undetermined manner [ ]

ACTUAL SIGNATURE: Paul C Van Natta M.D.
EXAMINER'S NAME (Type): PAUL C VAN NATTA
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED
Address (Street, city, town, or county): Pr Geo Co, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 27-62
22c. NAME OF CEMETERY OR CREMATORY: Holy Family Catholic
22d. LOCATION (City, town, or country) (State): Mitchellsville- Md.

23. FUNERAL DIRECTOR — ADDRESS: Charles B. Hicks III Annapolis, Maryland
24a. REC'D BY REGISTRAR — DATE: MAY 2 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kuna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04914

CERTIFICATE OF DEATH

Reg. Dist. No. 04913

1. PLACE OF DEATH
a. COUNTY: Prince Georges Hospital MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly MD
c. LENGTH OF STAY IN 16
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 66 East Riverdale
d. STREET ADDRESS: 5406- 62nd Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GERALD Middle WINFRED Last FOSTER

4. DATE OF DEATH: Month 4 Day 3 Year 19 62

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/4/82
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendent
10b. KIND OF BUSINESS OR INDUSTRY: Brick Yard
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Foster
14. MOTHER'S MAIDEN NAME: Sarah Ingoldsby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 177-01-7499
17. INFORMANT: Mrs Jean Boswell Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): GENERALIZED CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 yr.

153.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CARCINOMA of COLON
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CONGESTIVE HEART FAILURE. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 1960, 19___, to 4-3-, 19 62 that I last saw the deceased alive on 4-3-62, 19___, and that death occurred at 2:10 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Albert Roth M.D.
ADDRESS (Street, city or town, state): 8510 MADISON ST RIVERDALE
DATE SIGNED: 4-3-62

PHYSICIAN'S NAME (Type): Albert Roth

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-7-62
22c. NAME OF CEMETERY OR CREMATORY: Kittanning Cemetery
22d. LOCATION (City, town, or county) (State): Kittanning Penna

23. FUNERAL DIRECTOR'S SIGNATURE: W W Chambers
ADDRESS: Co. Riverdale Md

24a. REC'D BY REGISTRAR DATE: APR 6 62
24b. REGISTRAR'S SIGNATURE: Edith A. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

99

I

1

0

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04915

04914

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges County — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
   d. STREET ADDRESS: Box 363
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ROBERT Middle VERNON Last FOWLER

4. **DATE OF DEATH**: Month April Day 30, Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 22, 1959

9. AGE (In Years last birthday): 2 yrs. IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Cheverly, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Vernon Monroe Fowler

14. MOTHER'S MAIDEN NAME: Dorothy Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service): None

17. INFORMANT: Mrs. Vernon M. Fowler, Address Box 363 Lanham, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Toxic Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: —

085.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Measles — 2 weeks

DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none of Note

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): none

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Paul C. Van Natta M.D.

EXAMINER'S NAME (Type): PAUL C. VAN NATTA, M.D.

Address (Street, city, town, or county):

DATE SIGNED: May 1, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 4, 1962

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR ADDRESS: W. W. CHAMBERS CO., Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: MAY 3 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04916

CERTIFICATE OF DEATH

Items 10, 11, 12, 13 & 14 Film G213 5/17/62 mh

04915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 5 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 Cedar Heights
   d. STREET ADDRESS: 6230 Lee Place
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Tracy; Middle: ; Last: Garrison

4. **DATE OF DEATH**: Month: April; Day: 27; Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-3-09

9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Press Garrison

14. MOTHER'S MAIDEN NAME: Georgia Mathais

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio pulmonary Edema

DUE TO (b): Severe Hypertensive cardiovascular Dis.

DUE TO (c): Uremia

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: ; a.m. ☐ p.m. ☐; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. **I certify** that (I) (this hospital) attended the deceased from 4/22, 19 62 to 4/27, 19 62 that (I) (we) last saw the deceased alive on 4/27 19 62, and that death occured at 7:15, from the causes and on the date stated above.

22a. SIGNATURE: Caesar M. Madarang M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ A.M.

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Dr. Caesar M. Madarang

22d. ADDRESS: Prince George's General Hospital, Md. Cheverly,

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 1, 1962

23c. NAME OF CEMETERY OR CREMATORY: NAT'L HARMONY PARK

23d. LOCATION (City, town or county) (State): WASHINGTON, DC.

24 FUNERAL DIRECTOR'S SIGNATURE: Cameron Fun. Home,

ADDRESS: 611 K St. N.W.

25a. REC'D BY REGISTRAR DATE: MAY 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04917

CERTIFICATE OF DEATH

04916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 15 minutes
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   e. STATE: Maryland — b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (East Pines) Riverdale 66 1
   d. STREET ADDRESS: 6609 Oliver Street
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mary — Middle: Lorena — Last: GIBSON

4. **DATE OF DEATH**: Month: April — Day: 7, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: January 25, 1896

9. AGE (In years last birthday): 66 yrs.
   IF UNDER 1 YEAR: Months: -- Days: --
   IF UNDER 24 HRS.: Hours: -- Min.: --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid

10b. KIND OF BUSINESS OR INDUSTRY: Y.M.C.A.

11. BIRTHPLACE (County & State, or foreign country): Dinwiddie County, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S. of Am.

13. FATHER'S NAME: Samuel Johnson

14. MOTHER'S MAIDEN NAME: Mary Lou Langford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No --

16. SOCIAL SECURITY NO.: 579-28-2704A

17. INFORMANT: Address: Russel M. Carrell, 6609 Oliver St., Riverdale, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), end (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)	Acute Congestive Heart Failure	1½ hours
420.0 DUE TO (b)	Arteriosclerotic Heart Disease	10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Arteriosclerosis Generalized	30 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) - - - -

20c. TIME OF INJURY: Hour a.m. p.m. - - Month, Day, Year - - 19 --

20d. INJURY OCCURRED: While at work -- Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --

20f. (City or town) -- (County) -- (State)

21. **I certify** that (I) (this hospital) attended the deceased from October 11, 1961 to April 7, 1962, that (I) (we) last saw the deceased alive on March 27, 19 62, and that death occured at 1:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Walcutt W. Gibson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 7, 1962

22c. PHYSICIAN'S NAME (Type): Walcutt W. Gibson, M.D.

22d. ADDRESS: 4340 St. Barnabas Road, Washington 21, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	4-10-62	Cedar Hill	Suitland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: 300 40th St N.E.

25a. REC'D BY REGISTRAR DATE: APR 11 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A1S (4) 1SM 7/61

VR A12
5M 1/6

1
FOR STATE HEALTH DEPT.

M

99

1

2

0

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04917

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 61 Hyattsville
d. STREET ADDRESS: 4013 Longfellow Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sidney; Middle: ; Last: Gottley

4. DATE OF DEATH: Month: April; Day: 26; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 11, 1917

9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Metallurgist

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aaron Gottley

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Norval Eugene Jones, 209 Bradley Ave., Address Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Vascular Heart Disease — unknown
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none that I know

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): —

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town) (County) (State): —

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Paul C. Van Natta M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/26/62

EXAMINER'S NAME (Type): Paul C. Van Natta, M.D.
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/28/1962
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or country) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR
ADDRESS: The S.H.Hines Co.-2901 14th St., N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE: APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

DEPUTY MEDICAL EXAMINER: This ... any delay is necessary, ... ges 1, 2, and 3 to the funeral director. Page ... rm PM3. Page 5 may be retained for your files. ... e execute the certificate, writing the wor... should be forwarded to the Chief Medical E...
TO FUNERAL DIRECTOR: Page 3 should be u... ... permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cr... rtion, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04919

CERTIFICATE OF DEATH

04918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 10 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
   d. STREET ADDRESS: 6719 Fairwood Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Rosie — Middle: — Last: Graham

4. **DATE OF DEATH**: Month: Apr. — Day: 10 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 5, 1878

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Harrison

14. MOTHER'S MAIDEN NAME: Not Obtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mrs. Elsie Van Alstyne — Address: Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min.
420.0
DUE TO (b): Arteriosclerotic Heart disease — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/31, 19 62 to 4/10, 19 62, that (I) (we) last saw the deceased alive on 4/10 19 62, and that death occured at 6:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

22b. DATE SIGNED: Apr. 10 1962

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): F. E. Musser

22d. ADDRESS: 4410 74th Ave Landover Hills Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 13 April 62

23c. NAME OF CEMETERY OR CREMATORY: Methodist Protestant

23d. LOCATION (City, town or county) (State): Alexandria, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Cunningham Funeral Home, Inc. — W. Barby Mountcastle

ADDRESS: Alex., Va. Cameron & Alfred Sts

25a. REC'D BY REGISTRAR DATE: APR 13 '62

25b. REGISTRAR'S SIGNATURE: [signature]

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04920

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04919

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 Hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover Hills
d. STREET ADDRESS: 3815 72nd Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert — Middle: Paul — Last: Grimshaw

4. DATE OF DEATH: Month: April — Day: 16 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 29, 1956

9. AGE (In years last birthday): 5 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Gerald Grimshaw

14. MOTHER'S MAIDEN NAME: Janet Landgraf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Charles Gerald Grimshaw, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shock
DUE TO (b): Compaond fracture of the skull
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

812X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ xx

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)
Ran out from in front of a ~~parked~~ parked truck on road

20c. TIME OF INJURY — Hour: 2:50 xx p.m. — Month, Day, Year: 4/16/62

20d. INJURY OCCURRED — While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road

20f. (City or town): Landover (County): P. G. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒ xx, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: April 17, 1962

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/20/62

22c. NAME OF CEMETERY OR CREMATORY: Ft.Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Pr.Georges Co., Maryland

23. FUNERAL DIRECTOR: The S.H.Hines Co., — ADDRESS: 2901 14th St. N.W., Wash. D.C.

24a. REC'D BY REGISTRAR — DATE: APR 18 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04921

04920

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 2 Yrs. 10 Mons.
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): 5008-36th Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 5/1
d. STREET ADDRESS: 5008-36th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PERCY — Middle: LEE — Last: HALE

4. DATE OF DEATH: Month: APRIL — Day: 29 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DEC 16, 1880

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired, D.C. Government

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John W. Hale

14. MOTHER'S MAIDEN NAME: Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Anna E. Spencer — Address: above — Daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: SECONDS
DUE TO
(b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — many YEARS
DUE TO
(c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year — Hour o. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AUG 1, 1961, to PRESENT 19___, that (I) (we) last saw the deceased alive on APRIL 2, 1962, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul A. DeVore M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 29 APR 1962

22c. PHYSICIAN'S NAME (Type): PAUL A. DEVORE, M.D.

22d. ADDRESS: 3501 HAMILTON ST., HYATTSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/3/62

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

23d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home Inc.

ADDRESS: Mt. Rainier Md.

25a. REC'D BY REGISTRAR DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Clinton L. Timms

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04922

CERTIFICATE OF DEATH

07353

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
(Rev. 7-61)
6/15/62
mnb

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Beverly
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mitchelville
d. STREET ADDRESS: 1 Rt. #2, Box 41
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Henry — Middle: O. — Last: Harley

4. DATE OF DEATH: Month: April — Day: 3 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ **NEVER MARRIED** XX **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1-19-53

9. AGE (In years last birthday): 9 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Wallace Harley

14. MOTHER'S MAIDEN NAME: Helen Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Helen Turner, Mitchelville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a): Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 To.
201X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-21, 1962, to 4-3, 1962, that (I) (we) last saw the deceased alive on 4-3 1962, and that death occured at 11:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: Peter Duus M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/3/62

22c. PHYSICIAN'S NAME (Type): Dr. Peter Duus

22d. ADDRESS: 6124 Central Ave., Capitol Hgts., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/7/62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Nebo

23d. LOCATION (City, town or county) (State): Mitchelville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: George G. Kelson, Aquasco, Md.

25a. REC'D BY REGISTRAR DATE: JUL 5 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04923

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04921

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glendale
c. LENGTH OF STAY IN 1b: 14 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Marguerite Ave., Off Glendale Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 04 Glendale
d. STREET ADDRESS: 1 off Marguerite Ave/, Glendale Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Douglas; Middle Nesbet; Last Haselden

4. DATE OF DEATH: Month April; Day 24; Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 3, 1913

9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supply Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Barry Industries

11. BIRTHPLACE (State or foreign country): So. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stephen Osgood Haselden

14. MOTHER'S MAIDEN NAME: Rosa Lee Marlow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 317-01-6882

17. INFORMANT: Mary Eleanor Haselden Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARBON MONOXIDE POISONING

9733

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. 12:20 ☒ Month, Day, Year 4/24 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Residence

20f. (City or town) Glendale (County) P.G. (State) Maryland.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined manner ☒

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Paul C. Van Natta M.D.

EXAMINER'S NAME (Type): PAUL C. VAN NATTA, M.D.

Address (Street, city, town, or county):

DATE SIGNED: 4/24/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 27, 1962

22c. NAME OF CEMETERY OR CREMATORY: St Georges Episcopal

22d. LOCATION (City, town, or country) (State): Glendale, Md.

23. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville Md.

24a. REGISTERED DATE: APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

DATE: APR 30 '62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, the medical examiner should be notified immediately. He should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04924 04922

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
c. LENGTH OF STAY IN 1b: D.C.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): District Heights Medical Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parkland
d. STREET ADDRESS: 112 Druid Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nevin; Middle: Robert; Last: Haudenshild

4. DATE OF DEATH: Month: April; Day: 16th.; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 5, 1910

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ray Eugene Haudenshild

14. MOTHER'S MAIDEN NAME: Grace Sohn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give wer or dates of service): W.W. 11

16. SOCIAL SECURITY NO.: 276-03-8988

17. INFORMANT: Mary Kirkwood, 112 Druid Place
Address: Parkland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Cardiovascular renal disease.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 4/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-19-1962

22c. NAME OF CEMETERY OR CREMATORY: GREENLAWN CEMETERY

22d. LOCATION (City, town, or country) (State): TIFFIN, OHIO

23. FUNERAL DIRECTOR: W. W. Chambers Co.
ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: APR 18 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04925 04923

Item 9 Film G311 4/17/62 mh

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 12 hours
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 35 Glen Arden
   d. STREET ADDRESS: 1 8627 Johnson Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Sarah; Middle: ; Last: Hawkins

4. **DATE OF DEATH**: Month: April; Day: 6; Year: 1962

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-27-1893

9. AGE (In years last birthday): 68 / 69 yrs.
   IF UNDER 1 YEAR: Months ; Days
   IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): St Marys Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Barbour

14. MOTHER'S MAIDEN NAME: Emma M. Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Emma M. Washington — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema
DUE TO (b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4 2 0.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-6, 1962, to 4-6, 1962 that (I) (we) last saw the deceased alive on 4-6 1962, and that death occured at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Peter Duus M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: April 7, 1962

22c. PHYSICIAN'S NAME (Type): Peter Duus, M.D.

22d. ADDRESS: 6124 Central Ave., Capitol Heights, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-10-62

23c. NAME OF CEMETERY OR CREMATORY: Carmen Memorial Park

23d. LOCATION (City, town or county) (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE: 4504 GAULT JOHNSON JENKINS

ADDRESS:

25a. REC'D BY REGISTRAR DATE APR 11 '62

25b. REGISTRAR'S SIGNATURE: Charles L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04926

CERTIFICATE OF DEATH

04921

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 9 yrs., 6 months., 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X3
d. STREET ADDRESS: 4113 Beck St., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Ashton	N.	Hewitt

4. DATE OF DEATH	Month	Day	Year
	4	30	19 62

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Separated, not legally	1/13/1888	74 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Checker's Helper	Safeway	Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Hewitt	Anna Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	—	577-12-6145	Decedent	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.,

002.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Pulmonary tuberculosis — 9 yrs., 9 mo

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/10/ 6x 1952, to 4/30/, 1962., that (I) (we) last saw the deceased alive on 4/30/ 19 62., and that death occured at 1.M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 4/30/1962

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	May 2, 1962	Richland Church Cemetery	Stafford Co. Va.

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
F. Sacchi Son	4739 Baltimore Ave, Hyattsville, Md.	MAY 4 '62	Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04927 04925

1. **PLACE OF DEATH**
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 5111 W. Hyattsville
d. STREET ADDRESS: 2003 Somerset Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ethel — Middle: GERTRUDE — Last: Himelright

4. **DATE OF DEATH**: Month: April — Day: 24 — Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 17, 1887
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs Olga Krug. Address: Same as #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral thrombosis
DUE TO (c): Arteriosclerotic ~~Heart~~ Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
2Dd. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/16, 1962, to 4/24, 19 62 that (I) (we) last saw the deceased alive on 4/24 1962, and that death occured at 4:10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Hei K. Lee M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. Hei Kit Lee
22d. ADDRESS: P.G.H. 7733 Annapolis Rd. Lanham, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-27-1962
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem
23d. LOCATION (City, town or county) (State): Bladensburg, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: W. M. Chambers Co ADDRESS: Riverdale, Md
25a. REC'D BY REGISTRAR DATE: APR 30 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04928 04926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 2 hours
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PrinceGeorges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Maryland Park
   d. STREET ADDRESS: 6523 Coolidge Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: T — Last: Hogue Sr.

4. **DATE OF DEATH**: Month: April — Day: 21 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 28 Oct. 1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: BUILDING

11. BIRTHPLACE (County & State, or foreign country): Wash, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE. W. HOGUE

14. MOTHER'S MAIDEN NAME: ANNIE HUTCHINSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: LILLIAN. O. FERRITER — Address: 6736 MARLBORO PIKE SE

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction (Lower left ventricle) — 420.1

DUE TO (b): Left coronary arteriosclerotic occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Pulmonary edema, bilateral

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 21, 1962 to April 21, 1962, that (I) (we) last saw the deceased alive on April 21, 1962, and that death occured at 1.45 AM from the causes and on the date stated above.

22a. SIGNATURE: William Brain M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): WM BRAIN IN

22d. ADDRESS: 6124 Central Ave, Capitol Hgts Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-24-62

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem

23d. LOCATION (City, town or county): Suitland (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: Washington D.C.

25a. REC'D BY REGISTRAR DATE: APR 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04929

CERTIFICATE OF DEATH

04927

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

M

77

I

2

1

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 29
d. STREET ADDRESS: 513-68th Place (Seat Pleasant)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clifford — Middle: C. — Last: Hooker

4. DATE OF DEATH: Month: April — Day: 23 — Year: 19 62

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	☒ Married ☐ Never Married ☐ Widowed ☐ Divorced	11-26-1900	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	Painting	Arlington, Va.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Hooker	Matilda Bear

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
		Anna P. Hooker Wife above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Generalised Carcinomatosis	
162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b)	Bronchogenic Carcinoma	
DUE TO (c)	Metastasis to brain. Lt adrenal gld, Lt kidney.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — **19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — **20b.** DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 3/31, 1962, to 4/23, 1962, that (I) (we) last saw the deceased alive on 4/23 1962, and that death occured at 10:00, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒ / MED. DIRECTOR ☐ / STAFF PHYS. ☐	22b. DATE SIGNED
Max M. Herzberg			

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Dr. Max M. Herzberg	7016 Greig St., Seat Pleasant, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	4/26/62	Mt. Olivet	Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Malley's Funeral Home Inc, Mt. Rainier Md.	APR 27 '62	Arthur L. Timms

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04930 04928

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Use 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince George County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b: 4 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Manor Hyattsville Md. 4922 LaSalle Rd.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47X-3
d. STREET ADDRESS: 2700 Conn. Ave N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Josephine Middle: Sarah Last: Horigan

4. **DATE OF DEATH**: Month: April Day: 11 Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 28 1883

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Wahington D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James T. Clements

14. MOTHER'S MAIDEN NAME: Sarah Jett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. **INFORMANT**: Sister Agnes Patricia Address: Carroll Manor

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Collapse — INTERVAL BETWEEN ONSET AND DEATH: at death
DUE TO (b): Cerebral Thrombosis (repeated episodes) — 1 week
DUE TO (c): Cerebral Arteriosclerosis — 8 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 2 April, 1962 to 11 April, 1962, that (I) (~~we~~) last saw the deceased alive on 10th April 1962, and that death occured at 12.45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Louis A Craig M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12 April 62

22c. PHYSICIAN'S NAME (Type): LOUIS A. CRAIG, JR.

22d. ADDRESS: 1746 K ST N.W

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/14/62

23c. NAME OF CEMETERY OR CREMATORY: Holy Rood Cemetery

23d. LOCATION (City, town or county) (State): Washington D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: H. Don. DeVol ADDRESS: 2224 Wisconsin NW

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: William S. Triano

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04931 04929

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
c. LENGTH OF STAY IN 1b: WKS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suitland Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md. ~~D.C~~
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15 Washington
d. STREET ADDRESS: 302 Quade St.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: M. — Last: House

4. DATE OF DEATH: Month: April — Day: 21 — Year: 1962

5. SEX: F.

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1924

9. AGE (In years last birthday): 37 yrs.

IF UNDER 1 YEAR: Months: - Days: -

IF UNDER 24 HRS.: Hours: - Min.: -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Morgan

14. MOTHER'S MAIDEN NAME: Bertha Boyette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 243-30-1202

17. INFORMANT: Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malnutrition.
1530 DUE TO
(b): Carcinoma descending colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April, 1960, to April 21, 1962 that (I) (we) last saw the deceased alive on 4/17 1962, and that death occured at 8:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: D. Etienne Szollosi M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Etienne Szollosi M.D.

22d. ADDRESS: 2. Parkway Dr. Washington 21 - DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-24-62

23c. NAME OF CEMETERY OR CREMATORY: Falls Church Va

23d. LOCATION (City, town or county) (State): Nat Mem Park Cemetery

24 FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home

ADDRESS: 300 - 4 St NE Wash D.C.

25a. REC'D BY REGISTRAR DATE APR 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04932 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04930

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 04 Bowie
d. STREET ADDRESS: 10th and Zug Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hazel — Middle: Virginia — Last: Howard

4. DATE OF DEATH: Month: April — Day: 18 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 25, 1902

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Oden Howard Dugan

14. MOTHER'S MAIDEN NAME: Rosena Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Lewis Everett Howard, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
4201
DUE TO (b): Coronary heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Cardiovascular renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes of long standing

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: April 18, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/21/62
22c. NAME OF CEMETERY OR CREMATORY: Ivy Hill Cem.
22d. LOCATION (City, town, or country) (State): Laurel Md

23. FUNERAL DIRECTOR — ADDRESS: DeWitt Davidson, Laurel, Md

24a. REC'D BY REGISTRAR — DATE: APR 24 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1

FOR STATE HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04933

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04931

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Suitland
c. LENGTH OF STAY IN 1b: 2½ YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5110 Logan Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 5110 Logan Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle O. Last HUDGINS

4. DATE OF DEATH: Month April Day 10 Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 26 1908

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Mason

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Manson Hudgins

14. MOTHER'S MAIDEN NAME: Laura Bass

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): none
(If yes give war or dates of service): none

16. SOCIAL SECURITY NO.: 577_07*4408

17. INFORMANT: Mrs Hattie Hudgins — Address: Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Carcinoma of Lung — 9 Mon

DUE TO (c): unKnown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

163 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James E. Chapman M.D.

EXAMINER'S NAME (Type): James E. Chapman

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county): 2026 R ST NW Wash DC

DATE SIGNED: 10 Apr 62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/12/62

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or country) (State): Suitland Maryland

23. FUNERAL DIRECTOR: Lee Funeral Home — ADDRESS: 300 4th, St. N.E. Washington, D.C.

Robert G. Lee

24a. REC'D BY REGISTRAR: DATE APR 13 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

M

X

I

0

2

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04934

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04932

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill
c. LENGTH OF STAY IN 1b 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6317 Dominion Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Oxon Hill
d. STREET ADDRESS 6317 Dominion Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Ernestina Middle Galvez Last Huici

4. DATE OF DEATH Month April Day 10 Year 1962

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH April 13, 1879

9. AGE (In years last birthday) 82 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Spain

12. CITIZEN OF WHAT COUNTRY? Spain

13. FATHER'S NAME Manuel Galvez

14. MOTHER'S MAIDEN NAME Ortega

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Miguel Huici, Address same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO (b) Cerebrovascular renal disease
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D.

EXAMINER'S NAME (Type) James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED April 10, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

22b. DATE THEREOF 4/11/62

22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln

22d. LOCATION (City, town, or country) (State) Bladensburg, Md.

23. FUNERAL DIRECTOR W. W. Chambers Co.

ADDRESS 4th & L St. SE Washington, D.C.

24a. REC'D BY REGISTRAR DATE APR 13 '62

24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04935 04933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US AIR FORCE HOSPITAL ANDREWS

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DEALE
d. STREET ADDRESS: BOX 48 DEALE BEACH
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
02X-2

3. **NAME OF DECEASED** (Type or print): First: INFANT — Middle: BOY — Last: INMAN

4. **DATE OF DEATH**: Month: APRIL — Day: 14 — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12 APRIL 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): PRINCE GEORGES, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: UNITED STATES

13. FATHER'S NAME: JACK D INMAN

14. MOTHER'S MAIDEN NAME: MARY L MILLS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ATELECTASIS, CONGENITAL — INTERVAL BETWEEN ONSET AND DEATH: 32 HOURS

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): PREMATURE BIRTH

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 12 APRIL, 1962, to 14 APRIL, 1962, that ☒ (we) last saw the deceased alive on 14 APRIL 1962, and that death occured at 4AM, from the causes and on the date stated above.

22a. SIGNATURE: John A Moore M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 14 APRIL 1962

22c. PHYSICIAN'S NAME (Type): JOHN A MOORE, Major USAF MC

22d. ADDRESS: USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4-18-62 — 23c. NAME OF CEMETERY OR CREMATORY: Arlington Natl — 23d. LOCATION (City, town or county): F.H. Myer (State): Va

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers — ADDRESS: 519-11th St SE

25a. REC'D BY REGISTRAR — DATE: APR 18 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2-068252

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04936

CERTIFICATE OF DEATH

Reg. Dist. No. 04934

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier
c. LENGTH OF STAY IN 1b 16 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION 3711-34th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 Mt. Rainier
d. STREET ADDRESS 3711-34th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Elva Middle Matilda Last Johannes
4. DATE OF DEATH Month April Day 29 Year 1962
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 4/29/1882
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Harting
14. MOTHER'S MAIDEN NAME Ida Kroeger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-22-2164
INFORMANT Adeline Forrest Daughter Address above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Emphysema of Lungs, Advanced — INTERVAL BETWEEN ONSET AND DEATH 5 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Intertrochanteric Fracture right Femur 6 wks
DUE TO
(c)
5271

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Hypertensive Cardio Vascular Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/4, 1961, to 4/29, 1962, that I last saw the deceased alive on 4/10, 1962, and that death occurred at 1630 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Norman Donat Comeau M.D.
ADDRESS (Street, city or town, state) 3503 Bunker St.
DATE SIGNED 4/30/62
PHYSICIAN'S NAME (Type) Norman Donat Comeau Mt Rainier Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 5/2/62
22c. NAME OF CEMETERY OR CREMATORY Loudon Park
22d. LOCATION (City, town, or county) (State) Baltimore, Md

23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home, Inc.
ADDRESS Mt. Rainier Md.
24a. REC'D BY REGISTRAR DATE MAY 3 '62
24b. REGISTRAR'S SIGNATURE Clinton S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04937 — Item 5 from birth certificate — 04935

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 42 Hrs. 47 Min.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
   d. STREET ADDRESS: 23 Randall Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Baby Boy — Middle: — Last: Johnson

4. **DATE OF DEATH**: Month: April — Day: 5 — Year: 19 62

5. SEX: Male / ~~Female~~

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 3, 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS.: Hours: 18 — Min.: 47

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Cheverly Prince George's Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harold Eugene Johnson

14. MOTHER'S MAIDEN NAME: Wilma Gray Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

762.5

DUE TO (b): Bilateral Atelectasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-3, 19 62 to 4-5, 19 62 that (I) (we) last saw the deceased alive on 4-5 19 62, and that death occured at 12:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John W. Perkins M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. John W. Perkins

22d. ADDRESS: 5301 Hamilton Street, Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/6/62 — 23c. NAME OF CEMETERY OR CREMATORY: Johnson Family Burial Plot, Mt. Rainier Md. — 23d. LOCATION (City, town or county) (State): Newton Grove R.F.D. #2 N. Carolina

24. FUNERAL DIRECTOR'S SIGNATURE: Kalley's Funeral Home Inc. — ADDRESS: Mt. Rainier Md.

25a. REC'D BY REGISTRAR DATE: APR 9 '62 — 25b. REGISTRAR'S SIGNATURE: Clinton L. Rawe

2-046142

1

FOR STATE HEALTH DEPT.

M

99

1

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, give execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04936

1. PLACE OF DEATH
a. COUNTY: Prince Georges County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence Before Admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 N. Brentwood
d. STREET ADDRESS: 4703 WEBSTER ST [redacted]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLMORE Middle JOSEPH Last JOHNSON

4. DATE OF DEATH: Month April Day 24 Year 1962

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV 26. 1914

9. AGE (If years last birthday): 47 Years

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Trash Truck

11. BIRTHPLACE (State or foreign country): St. Mary's Cty. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ernest Johnson

14. MOTHER'S MAIDEN NAME: Annie Briscoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 579-09-9009

17. INFORMANT: unknown Yes Mrs. Bessie Queen,
Address: Route #1 Box 185 Lanham, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LOBAR PNEUMONIA
490 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul C. Van Natta M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): PAUL C. VAN NATTA, M.D.

Address (Street, city, town, or county):

DATE SIGNED: April 24, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-30-62

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.

22d. LOCATION (City, town, or country) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR: John T. Rhines & Company

ADDRESS: 3015 12th St. N. E.

24a. REC'D BY REGISTRAR DATE APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Rhines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04939 04937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residance before admission)
   a. STATE: M D.
   b. COUNTY: Prince Geo.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg 40
   d. STREET ADDRESS: 4405-56th Ave 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Laura — Middle: W — Last: Keller

4. **DATE OF DEATH**: Month: 4 — Day: 4 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Wh.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-6-1914

9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fab. Project Planner - Govt. worker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Wash. D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Wheatley

14. MOTHER'S MAIDEN NAME: Frances Burkhart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** Address: Hospital Records.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	
DUE TO (b)	Metastatic Carcinoma to Lungs.	2 months
DUE TO (c)	Carcinoma of Cervix	10 months

171X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March, 1961, to 3 April, 1962 that (I) (we) last saw the deceased alive on 3 April 1962, and that death occured at 5:55 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas M. Hutchin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-4-62

22c. PHYSICIAN'S NAME (Type): Thomas M Hutchin

22d. ADDRESS: 7315 Landover Rd. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/7/62

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons

ADDRESS: Hyattsville, Maryland

25a. REC'D BY REGISTRAR DATE APR 6 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04940 04938

1

M

50

I

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS .

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CAMP SPRINGS
d. STREET ADDRESS: 5571 MAXWELL DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAWN — Middle MARIE — Last KENNEDY

4. DATE OF DEATH: Month APRIL — Day 3 — Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 27 December 1960

9. AGE (In years last birthday): 1 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): PHILIPPINE ISLANDS

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: THOMAS JAMES KENNEDY

14. MOTHER'S MAIDEN NAME: BEATRICE A FREESE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NA

16. SOCIAL SECURITY NO.: NA

17. INFORMANT Address: THOMAS J SMITH(FATHER) SAME AS #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
DUE TO (b): Congenital heart disease — 1 year
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stoting the underlying cause last.

75 4.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 3 Apr 1962 to 3 Apr 1962 that (I) (~~he~~) last saw the deceased alive on 3 Apr 1962, and that death occurred at 1140 M, from the causes and on the date stated above.

22a. SIGNATURE: John A Moore M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 3 APRIL 1962

22c. PHYSICIAN'S NAME (Type): JOHN A MOORE, Major USAF MC

22d. ADDRESS: USAF HOSP, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: April 5, 1962
23c. NAME OF CEMETERY OR ~~CREMATORY~~: ARLINGTON NATIONAL
23d. LOCATION (City, town, or county) (State): ARLINGTON VIRGINIA

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. CHAMBERS CO.
ADDRESS: 517 11th ST SE Wash. D.C.

25a. REC'D BY REGISTRAR DATE: APR 6 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04941

CERTIFICATE OF DEATH

04939

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
   c. LENGTH OF STAY IN 1b: 66 Years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Clinton, Maryland.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Pr. Geo's Co.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Clinton, Maryland
   d. STREET ADDRESS: Clinton, Maryland.
   e. IS RESIDENCE ON A FARM? YES [XX] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: WILLIAM — Middle: BERNARD — Last: KING

4. **DATE OF DEATH**: Month: April — Day: 17th — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [XX] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: April 26- 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry King

14. MOTHER'S MAIDEN NAME: Adelaide White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Cora Murphy 338 - Raleigh St. S. E. Wash., Dc.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CORONARY ARTEIOSCLEROSIS — YEARS

DUE TO (c): GENERAL ARTERIOSCLEROSIS — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from NOV 15, 19 61, to APR 17, 19 62, that (I) (we) last saw the deceased alive on APR 17 19 61, and that death occured at 11:25AM the causes and on the date stated above.

22a. SIGNATURE: Paul Chen, M.D. M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: APRIL 17, 1962

22c. PHYSICIAN'S NAME (Type): PAUL CHEN, M. D.

22d. ADDRESS: ACCOKEEK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April-19-62

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Suitland, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Brothers — ADDRESS: 1661 Good Hope Rd SE Washington DC.

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur J. Fenner

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04942 04940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: PRINCE GEORGE — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
   c. LENGTH OF STAY IN 1b: adm. 7-17-56
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): LAUREL SANITARIUM

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 3 V01-4
   d. STREET ADDRESS: 3303 N. CHARLES St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First SALLY Middle BRUCE Last KINSOLVING
4. **DATE OF DEATH**: Month 4 Day 27 Year 1962
5. **SEX**: Female
6. **COLOR OR RACE**: WHITE
7. **MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. **DATE OF BIRTH**: 2-14-1876
9. **AGE** (In years last birthday): 86 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.
10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): housewife
10b. **KIND OF BUSINESS OR INDUSTRY**: ÷
11. **BIRTHPLACE** (County & State, or foreign country): VIRGINIA
12. **CITIZEN OF WHAT COUNTRY?**: U.S.A.
13. **FATHER'S NAME**: THOMAS SEDDON BRUCE
14. **MOTHER'S MAIDEN NAME**: MARY ANDERSON
15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): unknown
16. **SOCIAL SECURITY NO.**: ÷
17. **INFORMANT**: Hosp. Records — Address: LAUREL SANITARIUM

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac fibrillation (433.1)	1 minute
DUE TO (b)	arteriosclerotic heart disease	many yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): unspecified chronic pulmonary disease

19. **WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. / p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-17- 19 56 to 4-27- 19 62, that (I) (we) last saw the deceased alive on 4-27- 19 62, and that death occured at 7:05 A M, from the causes and on the date stated above.

22a. SIGNATURE: Erika P. Kraemer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 4-27-62
22c. PHYSICIAN'S NAME (Type): ERIKA P. KRAEMER
22d. ADDRESS: LAUREL SANITARIUM LAUREL Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-28-62
23c. NAME OF CEMETERY OR CREMATORY: St. Thomas's Church
23d. LOCATION (City, town or county) (State): Garrison, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: John O. Mitchell & Sons, ADDRESS
John O Mitchell & Sons
25a. REC'D BY REGISTRAR DATE MAY 1 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Knuth

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04943 Item 8 Film G312 5/14/62 mh 04911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 24 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 66 Riverdale
   d. STREET ADDRESS: 6314 Patterson Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Henry — Middle: — Last: Kumm

4. **DATE OF DEATH**: Month: April — Day: 26 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9 Jan 1893 ?

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter Retired

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Kumm

14. MOTHER'S MAIDEN NAME: Elizabeth Essenburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Henry Kumm Jr. — Address: Same as #2 (son)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcimona of prostate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Possible Right Pulmonary Metastasis

DUE TO (c): Bone Metastasis Ilium Bone

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19.....; that (I) (we) last saw the deceased alive on .....19....., and that death occured at 5.30A.M. from the causes and on the date stated above.

22a. SIGNATURE: Sam B. Bachrach MD — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. L. Backrack., M.D.

22d. ADDRESS: 915 19th St., N.W., Washington 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/30/62 — 23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln — 23d. LOCATION (City, town or county): Colmar Manor, (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Marchi's Sons — ADDRESS: Hyattsville, md.

25a. REC'D BY REGISTRAR DATE: MAY 1 '62 — 25b. REGISTRAR'S SIGNATURE: Anthony S. Krause

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04944

CERTIFICATE OF DEATH

04942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 12 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
d. STREET ADDRESS: 10678 Edmonston Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter; Middle: ; Last: Lampkin

4. DATE OF DEATH: Month: April; Day: 22,; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2-14-13

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machanic

10b. KIND OF BUSINESS OR INDUSTRY: W.S.S.C.

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Lampkin

14. MOTHER'S MAIDEN NAME: Callie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): yes — WW 11

16. SOCIAL SECURITY NO.: 232-18-3782

17. INFORMANT Address: Clara M. Lampkin Same as #2 Wife

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anemia — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
DUE TO (b): Chronic Pyelonephritis — 2 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

600.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c): Hypertensive Cardio Vascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. p.m. Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-10-, 1962 to 4-22-, 1962, that (I) (we) last saw the deceased alive on April 22, 1962, and that death occured at 6:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Norman Donat Comeau M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/22/62

22c. PHYSICIAN'S NAME (Type): Norman Donat Comeau

22d. ADDRESS: 3503 Perry St Mt Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/25/62

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Va.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Frederick Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: APR 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04945 04943

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS
c. LENGTH OF STAY IN 1b: 47 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAF HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CAMP SPRINGS
d. STREET ADDRESS: 1 ANDREWS AFB MD (NAF)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS Middle LEO Last LEONARD

4. DATE OF DEATH: Month APRIL Day 22 Year 1962

5. SEX: MALE
6. COLOR OR RACE: CAU
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 22 OCTOBER 1939
9. AGE (In years last birthday): 22 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SAILOR
10b. KIND OF BUSINESS OR INDUSTRY: US NAVY
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: RITA LEONARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): PRESENT
16. SOCIAL SECURITY NO.: 174-32-6225
17. INFORMANT: JOSEPH F SPENCE, COUSIN, Address 931 TURNER AVE DREXEL HILL, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aplastic Anemia — INTERVAL BETWEEN ONSET AND DEATH: 47 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 292.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6 Mar 1962, to 22 April 1962 that (I) (we) last saw the deceased alive on 22 April 1962, and that death occurred at 0750 M, from the causes and on the date stated above.

22a. SIGNATURE: Barry Ladd M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 22 April 62
22c. PHYSICIAN'S NAME (Type): BARRY LADD, CAPT, USAF, MC
22d. ADDRESS: USAF HOSPITAL, ANDREWS AFB MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4/24/62
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): NORWOOD PENNA

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: 1400 Chapin St NW Washington DC
REC'D BY REGISTRAR DATE: APR 25 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kinard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

M

77

I

2

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04946 04944

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 mos. 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 66 East Pines
d. STREET ADDRESS: 1 6313 Riverdale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clement; Middle: John; Last: Lindsay

4. DATE OF DEATH: Month: April; Day: 6; Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-5-90

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W. Lindsay

14. MOTHER'S MAIDEN NAME: Florence Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 579-28-6083

17. INFORMANT: Ralph E. Lee — Address: 5903 67th Ave. Riverdale, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PURULENT MENINGITIS 812X
DUE TO (b): DECUBITI ULCERS
DUE TO (c): FRACTURE RT FEMUR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Pedestrian struck by an automobile

20c. TIME OF INJURY: Hour 1:30 a.m. p.m. — Month, Day, Year: 12-9 1961

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 6 Street

20f. (City or town): Riverdale (County): P. G. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): Dr. James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
DATE SIGNED: April 6. 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/10/62
22c. NAME OF CEMETERY OR CREMATORY: Congressional
22d. LOCATION (City, town, or country): Washington D. C. (State):

23. FUNERAL DIRECTOR: Francis Gasch's Sons
ADDRESS: Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE: APR 12 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Item 20c Film 515 5-22

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04947

04945

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE'S
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PRINCE GEORGE'S GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Georgia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alma
d. STREET ADDRESS: Route # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

49X-3

3. NAME OF DECEASED (Type or print): First MARCUS Middle Claude Last LONG

4. DATE OF DEATH: Month April Day 15, Year 19 62

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 22, 1912
9. AGE (In years last birthday): 49 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Electrical
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Marcus C. Long
14. MOTHER'S MAIDEN NAME: Nettie Darby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): W.W. 11
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Marcus C. Long Address: Route # 1 Alma, Georgia.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Aspiration of food
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

9 21 16

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Was eating his dinner and aspirated some food
20c. TIME OF INJURY Hour a.m. XX p.m. 6:10 Month, Day, Year April 16/62
20d. INJURY OCCURRED While at work ☐ Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Inn
20f. (City or town) Bladensburg (County) P. G. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes ☐, Accident [X], Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 4/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Apr.18,1962
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or country) (State): Alma, Georgia

23. FUNERAL DIRECTOR ADDRESS: W. W. CHAMBERS CO., Riverdale, Md.

24c. REC'D BY REGISTRAR DATE: APR 18 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

JAMES I. FOYD, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04948 04946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 2 Hrs. 44 Mins.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   e. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glen Arden
   d. STREET ADDRESS: 7919 Fiske Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Baby Girl (A) — Middle: — Last: Lounderman

4. **DATE OF DEATH**: Month: April — Day: 5 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 5, 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 2 — Min.: 44

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Graham Lambert Lounderman Jr.

14. MOTHER'S MAIDEN NAME: Ida Mae Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 1½ hr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Prematurity — 5 hr

DUE TO (c): Pre-mature Labor

7766

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-5, 1962, to 4-5, 19 62 that (I) (we) last saw the deceased alive on 4-5 19 62, and that death occured at 8:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Henry A. Wise Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Henry A. Wise Jr. — 22d. ADDRESS: 9005 Volta St, Lanham, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 23b. DATE THEREOF: 4-13-62 — 23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital — 23d. LOCATION (City, town or county) (State): Cheverly, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Administrator — ADDRESS:

25a. REC'D BY REGISTRAR DATE APR 23 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A1S (4) 15M 7/61

2-046039

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04949 — 04947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 Hrs. 42 Mins.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glen Arden
d. STREET ADDRESS: 7919 Fiske Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy (B) Middle: Last: Lounderman
4. DATE OF DEATH: Month: April Day: 5 Year: 1962

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 5, 1962
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: 2 Min.: 42

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Graham Lambert
14. MOTHER'S MAIDEN NAME: Ida Mae Woods

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b): Prematurity
DUE TO (c): Pre-mature Labor
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 1/2 hrs 5 hr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-5, 19 62 to 4-5, 19 62, that (I) (we) last saw the deceased alive on 4-5 19 62, and that death occured at 8:30, from the causes and on the date stated above.

22a. SIGNATURE: Dr Henry A. Wise Jr M.D.
ATTENDING PHYS. ☒ P.M. MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Henry A. Wise Jr
22d. ADDRESS: 9005 Volta St, Lanham, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 4-13-62
23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital
23d. LOCATION (City, town or county) (State): Cheverly, Md.

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Harry W. Penn, Jr., Administrator
25a. REC'D BY REGISTRAR DATE: APR 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

2-046038

FOR STATE HEALTH DEPT. 13

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04950 — Items 4, 8 & 22 Film 0311 4/16/62 mh — 03641

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
c. LENGTH OF STAY IN 1b: MARYLAND DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Airforce Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Chalres
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
d. STREET ADDRESS: M.C.A. Housing Apt 11
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ X

3. NAME OF DECEASED (Type or print): First Orsoline Middle Marie Last Lowmiller

4. DATE OF DEATH: Month April March Day 3 Year 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July Sept. 24, 1926
9. AGE (If years last birthday): 35 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Virgilo Bonati
14. MOTHER'S MAIDEN NAME: Josephine UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Robert Eugene Lowmiller, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH
191.3
DUE TO (b): HYPERTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): TUMOR OF RIGHT ADRENAL GLAND

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ X NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ X, Inspection ☒ X, Inquiry ☒ X and in my opinion death resulted from: Natural causes ☒ X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ X
Address (Street, city, town, or county):
DATE SIGNED: April 3, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4/6/62
22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery ~~HIGHSPIRE CEMETERY~~
22d. LOCATION (City, town, or county) (State): HIGHSPIRE Harrisburg PA.

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO.
ADDRESS: 5801 CLEVELAND AVE. RIVELDALE, Md.

24a. REC'D BY REGISTRAR DATE: APR 6 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04951 Item 2 Film 0311 1/17/62 mh 04948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hyattsville
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Manor

2. **USUAL RESIDENCE** (Where deceased lived, if institution; Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George's
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Washington
   d. STREET ADDRESS: 1632 Primrose Rd. N.W.
   IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First VIRGINIA — Middle T. — Last MAHAN

4. **DATE OF DEATH**: Month April — Day 10 — Year 1962

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 1-16-1896 — 9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: - - - - — 11. BIRTHPLACE (County & State, or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Martin Thompson — 14. MOTHER'S MAIDEN NAME: Elizabeth Rebecca Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) - — (If yes give wer or dates of service) - - - — 16. SOCIAL SECURITY NO. - - - — 17. INFORMANT: Betty Jane Doyle — Address: 5807 Wiltshire Dr. Washington, D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO (b) Carcinoma rectum — 4 mos
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

154.X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov, 1958, to Apr 10, 1962, that (I) (we) last saw the deceased alive on Apr 5 1962, and that death occured at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Apr 19, 1962

22c. PHYSICIAN'S NAME (Type) J. E. Fitzgerald — 22d. ADDRESS: Georgetown University Hospital Washington, D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4-13-1962 — 23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery, — 23d. LOCATION (City, town or county) Arlington, (State) Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Son Inc. — ADDRESS: 1756 Pa. Ave. N.W. (Wash. 6, D.C.)

25a. REC'D BY REGISTRAR DATE APR 12 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04952 — 04949

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 5M 1/62

1. PLACE OF DEATH
   a. COUNTY: Prince George's
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersbury 15x2
   d. STREET ADDRESS: RFD#3
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First RALPH; Middle EUGENE; Last MANUEL

4. DATE OF DEATH: Month April; Day 14; Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 21, 1907

9. AGE (In years last birthday): 54 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Horseman

10b. KIND OF BUSINESS OR INDUSTRY: Horses

11. BIRTHPLACE (State or foreign country): Maine

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herbert (n) Manuel

14. MOTHER'S MAIDEN NAME: Ida Evelyn Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Evelyn G. Manuel Address: 2500 Wusconsin Ave., NW Washington, DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hemorrhage and shock

DUE TO (b): Crushed chest and skull

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) overturne

Driver of an automobile that ran off the road and

20c. TIME OF INJURY: Hour a.m. 4:30 Month, Day, Year 4/14/62

20d. INJURY OCCURRED: While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Parkway

20f. (City or town) Greenbelt (County) P. G. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X] Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X] Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county):

DATE SIGNED: 4/14/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-18-62

22c. NAME OF CEMETERY OR CREMATORY: Washington National

22d. LOCATION (City, town, or country) (State): Suitland, Maryland

23. FUNERAL DIRECTOR: W. W. Chamber Co. ADDRESS: 3072 - M. H. N. W.

24a. REC'D BY REGISTRAR DATE: APR 17 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04953 04950

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Mount Rainier
d. STREET ADDRESS: 4308 Russell Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Irene — Last: McAllister

4. DATE OF DEATH: Month: April — Day: 11, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8. DATE OF BIRTH: July 5, 1889

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Henry Taylor

14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: 4849 Queens Chapel Terr — Joseph Henry McAllister Jr. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO (b): Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes, obesity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/11/62

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 14, 1962
22c. NAME OF CEMETERY OR CREMATORY: Ford Lincoln
22d. LOCATION (City, town, or country) (State): Bladensburg Md.

23. FUNERAL DIRECTOR: Neal Funeral Home — ADDRESS: 4812 Da ...

24a. REC'D BY REGISTRAR DATE: APR 16 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04954

04951

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MADISON MANOR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON. 47X·3
d. STREET ADDRESS: 4330 Valley Terrace SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REX Middle — Last McHONEY

4. DATE OF DEATH: Month April Day 25 Year 1962.

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7-30-1889

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED.

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U-S.

13. FATHER'S NAME: Christopher McHONEY

14. MOTHER'S MAIDEN NAME: Lucina Maxey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 322-10-0635

17. INFORMANT: Glenda B McClenning Address 4330 Valley Ter Washington DC

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 19 60 to Apr 25 1962 that (I) (we) last saw the deceased alive on 4, 27. 19 62 and that death occurred at 6:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Bernard Katzen, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4.27.62.

22c. PHYSICIAN'S NAME (Type): BERNARD KATZEN M.D.

22d. ADDRESS: 3520 - Minn - Ave - SE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-4-62

23c. NAME OF CEMETERY OR CREMATORY: Hollsville

23d. LOCATION (City, town, or county) (State): Hollsville Md

24. FUNERAL DIRECTOR'S SIGNATURE: J. W. LEE

ADDRESS: 3004 FT N.E.

25a. REC'D BY REGISTRAR DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04955 Item 7FilmG311 4/13/62 jwk 04952

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hyattsville
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Paint Branch Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berwyn Heights 68
d. STREET ADDRESS: 8521 58 Ave
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: A. — Last: McNamara

4. DATE OF DEATH: Month: April — Day: 4 — Year: 1962

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	Cauc	Single	2-28-1884	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Lady.	Specialty Shop.	New York City	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas McNamara.	Margaret McAleer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	076-10-2301	Anna W. McNamara	SAME AS #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized abdominal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

165X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): = Metastasis to lungs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 6[4] to April 6[2], 19..., that (I) (we) last saw the deceased alive on March 29 19 62, and that death occured at 8:35 AM, from the causes and on the date stated above.

22a. SIGNATURE: W. C. Etienne M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): W. C. ETIENNE — 22d. ADDRESS: College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Apr 9, 1962	St Charles Cemetery	Freeport New York

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
F. Gasch's Sons Hyattsville, Md.	APR 6 '62	Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04956

CERTIFICATE OF DEATH

04953

Information from birth cert.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 45 Brentwood
d. STREET ADDRESS: 4014 Webster ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle: — Last: Mickles

4. DATE OF DEATH: Month: 4- — Day: -22 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: C

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4-18-62

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: — Days: 5 IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Willie James Mickle

14. MOTHER'S MAIDEN NAME: Marian T. Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ATELECTASIA — INTERVAL BETWEEN ONSET AND DEATH: LIFE

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): PREMATURITY — LIFE.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-18, 1962 to 4-22, 1962 that (I) (we) last saw the deceased alive on 4-22 1962 and that death occured at 8:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: S.V. Battiata M.D. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/23/62

22c. PHYSICIAN'S NAME (Type): S.V. BATTIATA M.D.

22d. ADDRESS: 7309 RIGGS RD HYATTSVILLE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/24/1962

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: John R. Baker

ADDRESS: W. Ernest Jarvis Co., Inc. 1432 You Street, N.W.

25a. REC'D BY REGISTRAR: APR 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

2-046508

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04957 04954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Clinton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Southern Maryland

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince Geos Co
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Clinton, Md
   d. STREET ADDRESS: Rt 1, Box 649-
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Martha — Middle: Irene — Last: Miller

4. **DATE OF DEATH**: Month: April — Dey: 4 — Yeer: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4 July 190x

9. AGE (In yeers last birthday): 59 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John a. Fahey

14. MOTHER'S MAIDEN NAME: Olivia Garner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harry J. Miller — Address: Same # 2

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), end (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	2 hours
DUE TO (b)	Cardiovascular Disease	4 days
Conditions, if any, which gave rise to immediate cause (a), steting the underlying ceuse lest. DUE TO (c)	Arteriosclerosis, Generalized	2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July, 1957 to April 4, 1962 that (I) (we) last saw the deceased alive on 4/4 1962, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Alfred R Lapin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ALFRED R. LAPIN

22d. ADDRESS: CLINTON, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: April 7-62 — 23c. NAME OF CEMETERY OR CREMATORY: St Johns Cemetery — 23d. LOCATION (City, town or county) (State): Clinton Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Semmes Bros — ADDRESS: 1661-9th Hyattsville Md

25a. REC'D BY REGISTRAR DATE APR 6 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

next page

1

FOR STATE HEALTH DEPT.

M

76

I

0

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04958

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04955

1. PLACE OF DEATH
a. COUNTY: Prince George's
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 10 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Colmar Manor
d. STREET ADDRESS: 3406 43rd Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle Schlorb Last MOCKABEE

4. DATE OF DEATH: Month April Day 14 Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 2,1895

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George L. Schlorb

14. MOTHER'S MAIDEN NAME: Mary Ellen Donaldson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 722-05-0339

17. INFORMANT: Paul Francis Mockabee Address: 9100 Central Ave. Randolph Village MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 442X Acute congestive heart failure
DUE TO (b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes XXX Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 4/14/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-17-1962

22c. NAME OF CEMETERY OR CREMATORY: Addison Chapel.

22d. LOCATION (City, town, or country) (State): Seat Pleasant, Md

23. FUNERAL DIRECTOR: W. W. Chambers Co ADDRESS: Riverdale, Md

24a. REC'D BY REGISTRAR DATE APR 17 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04959

CERTIFICATE OF DEATH

04956

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park 70
d. STREET ADDRESS: 9314 - 49th. Ave. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Icy — Middle: Delphia — Last: Moore

4. **DATE OF DEATH**: Month: April — Day: 14, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-5-74

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** — Address: Robert W. Moore — 1322-V-St., S. E. Wash. DC

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO (b): Arterio-sclerotic Cardio-vascular disease — 5 yrs +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-13- 19 62 to 4-14-, 19 62 that (I) (we) last saw the deceased alive on April 14, 19 62, and that death occured at 9:30 P.M. the causes and on the date stated above.

22a. SIGNATURE: W.L. Etienne M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/5/62

22c. PHYSICIAN'S NAME (Type): W.L. ETIENNE

22d. ADDRESS: College Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: april 18-62 — 23c. NAME OF CEMETERY OR CREMATORY: East Hill Cemetery — 23d. LOCATION (City, town or county) (State): Salem Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros. — ADDRESS: 1661- Hope rd SE Wash. 20 D.C.

25a. REC'D BY REGISTRAR DATE APR 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04960 — 04957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex... within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Capital Heights 27
d. STREET ADDRESS: 304 - 48th. Ave. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna — Middle: MARTHA — Last: Murphy

4. DATE OF DEATH: Month: April — Day: 25, — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 1-19-95

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SUPT. G.S.A.

10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVT'L. RET.

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ALEXANDER HUGES

14. MOTHER'S MAIDEN NAME: JESSIE FLETCHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO

(If yes give wer or dates of service): NONE

16. SOCIAL SECURITY NO.: 577-03-5443

17. INFORMANT: JOHN D. MURPHY — Address: 6508 MARLBORO PIKE WASH. 28 D.C. (SON)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH

237 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bilateral Pulmonary Edema

DUE TO (c): Arterosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 22, 1962, to April 25, 19 62 that (I) (we) last saw the deceased alive on April 25, 19 62, and that death occured at 11:00 P.M. due to the causes and on the date stated above.

22a. SIGNATURE: Hei K. Lee M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Hei Kit Lee

22d. ADDRESS: 7730 Annapolis Rd., Lanham, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/30/62

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

23d. LOCATION (City, town or county) (State): ARLINGTON VA.

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: 517 11th ST. S.E. WASHINGTON, D.C.

25a. REC'D BY REGISTRAR DATE MAY 2 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Rhoads

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04961

CERTIFICATE OF DEATH

04958

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 7 Hrs. 7 Mins.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS: 569 Hill Road, Huntsville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Girl — Middle: — Last: Newman

4. DATE OF DEATH: Month: April — Day: 24 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 24, 1962

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 7 / Min. 7

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Prince George's, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Harold Newman

14. MOTHER'S MAIDEN NAME: Irene Cecelia Robinson Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac temponade — INTERVAL BETWEEN ONSET AND DEATH: Life

7710

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Atelectasis of left lung — Life

DUE TO (c): Hemothorax left side — Life

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-24, 19 62 to 4-24, 19 62, that (I) (we) last saw the deceased alive on 4-24 19 62, and that death occured at 12:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph McDonald M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 4/26/62

22c. PHYSICIAN'S NAME (Type): Dr. Joseph O. McDonald

22d. ADDRESS: 7309 Riggs Rd., W.Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: May 5, 1962

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr. — ADDRESS: Administrator

25a. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04962

CERTIFICATE OF DEATH

Reg. Dist. No. 04959

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
c. LENGTH OF STAY IN 1b: (4yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3717 - Shepherd St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood 46
d. STREET ADDRESS: 3717 - Shepherd St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patricia — Middle: Dawes — Last: Nuzzo

4. DATE OF DEATH: Month: 4 — Day: 30 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒
8. DATE OF BIRTH: Oct. 28 1905
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Government
10b. KIND OF BUSINESS OR INDUSTRY: Treasury Dept
11. BIRTHPLACE (State or foreign country): St. Thomas Virgin Isl.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Duerloo
14. MOTHER'S MAIDEN NAME: Margaret Vaughn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Barbara Underwood — Address: 101 Beaver Dam Rd Bethesda Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH
175.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of Ovary
DUE TO (c): Congestive heart failure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Ascites and Pleural effusion
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1960, 19__, to 4/29, 1962 that I last saw the deceased alive on 4/29, 1962, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: MARINO SORVILL M.D. — ADDRESS (Street, city or town, state): 2802 - Wells. Road Silver Spring, Md. — DATE SIGNED
PHYSICIAN'S NAME (Type): Marino Sorvill

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/2/62
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Nalley's Funeral Home Inc.
ADDRESS: Mt. Rainier Md.
24a. REC'D BY REGISTRAR DATE: MAY 3 '62
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04963

CERTIFICATE OF DEATH

04960

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bladensburg
   c. LENGTH OF STAY IN 1b: 8 mo
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): x

2. **USUAL RESIDENCE** (Where deceased livad, If institution, Residance before admission)
   a. STATE: Maryland — b. COUNTY: Prince Geo.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg 40
   d. STREET ADDRESS: 4000 - 53 ~~ave~~ ST
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First AMOS Middle CHARLES Last OGBURN

4. **DATE OF DEATH**: Month april Day 5 Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov 7 1874

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Pine Village Indy, USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles William Ogburn

14. MOTHER'S MAIDEN NAME: Nancy ann ~~Price~~ Shipmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Mr Roy Ogburn — Address: 4000 53 St Bladensburg md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Exhaustion	4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Cerebral hemorrhage	4 days
DUE TO (c)	Arterio Sclerosis	years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.): no

20c. TIME OF INJURY: Hour a.m. p.m. Month, Dey, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospitel) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on .....19....., and that death occured at 7:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Dayton O Watkins M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-5-62

22c. PHYSICIAN'S NAME (Type): DAYTON O WATKINS

22d. ADDRESS: 5318 annapolis Rd Bladensburg, md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/8/1962

23c. NAME OF CEMETERY OR CREMATORY: Mummasburg Cemetery

23d. LOCATION (City, town or county) (State): Franklin Twp. Adams Co. Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Walter Bender

ADDRESS: Gettysburg Penna.

25a. REC'D BY REGISTRAR DATE: APR 9 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04964 **CERTIFICATE OF DEATH** 04961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
   c. LENGTH OF STAY IN 1b: 3 months & 11 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: D. C.
   b. COUNTY: —
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
   d. STREET ADDRESS: 1827 Corcoran St., N.W.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: Joseph — Middle: C.- — Last: O'Neill, Sr.

4. **DATE OF DEATH**: Month: 4 — Day: 23 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/28/09

9. AGE (In years last birthday): 52 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles O'Neill

14. MOTHER'S MAIDEN NAME: Esther Charashaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Decedent — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the larynx with metastases
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

161X

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.,

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Left radical neck dissection, 6/61

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/12/ 3:00 1962, to 4/23/, 1962., that (I) (we) last saw the deceased alive on 4/23/ 19 62., and that death occured at P.M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐

22b. DATE SIGNED: 4/23/1962

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/27/62

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Dumphred

ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04965 (crossed out) 04962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
   c. LENGTH OF STAY IN 1b: 6 months and 16 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: D.C.
   b. COUNTY: -
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
   d. STREET ADDRESS: 824 Buchannan St., N.E.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elizabeth — Middle: - — Last: Parker

4. **DATE OF DEATH**: Month: 4 — Day: 1 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/6/1886

9. AGE (In years last birthday): 76 yrs.
   IF UNDER 1 YEAR: Months: - Days: -
   IF UNDER 24 HRS.: Hours: - Min.: -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Scott

14. MOTHER'S MAIDEN NAME: Emma Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Elizabeth Parker (daughter) address unknown
    Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — unknown
DUE TO (c):

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9/16 1961 12:05 to 4/1, 1962, that (I) (we) last saw the deceased alive on 4/1 19 62, and that death occured at A.M. from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 4/1/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 4, 1962

23c. NAME OF CEMETERY OR CREMATORY: Johnson Funeral Home

23d. LOCATION (City, town or county) (State): Franklin, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: ALEXANDER S. POPE FUNERAL DIRECTORS

ADDRESS: 414 16th St. S.E. Washington 3, D. C.

25a. REC'D BY REGISTRAR DATE: APR 6 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

99

M

I

2

2

BP

VR A15ME
5M 1/62

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04966

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04963

1. PLACE OF DEATH

a. COUNTY: Prince George's — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly

c. LENGTH OF STAY IN 1b: DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: Maryland

b. COUNTY: Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville

d. STREET ADDRESS: 4003 Queensbury Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

6, 1

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Elizabeth	Agnes	Payne	April	21	1962

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Nov. 8, 1903	58 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Delicatessen	West Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNKNOWN Welty	Jennie Crim

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	UNKNOWN	Betty Jane Knight, 4005 Queensbury Road Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intracerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

331X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐ ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: April 21, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
BURIAL	4-25-1962	FORT LINCOLN CEM	BLADENSBURG, MARYLAND

23. FUNERAL DIRECTOR: W.W. Chambers Co ADDRESS: Riverdale, Maryland

24a. REC'D BY REGISTRAR DATE: APR 24 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04967

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04964

Item 8 Film G312 5/14/62 mh

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 mos. 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Upper Marlboro
d. STREET ADDRESS: Box 101
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary; Middle: L.; Last: Payton

4. DATE OF DEATH: Month: April; Day: 26; Year: 1962

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-10-16 1917

9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Scrivner

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Jackson — Address: Upper Marlboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple Pulmonary Emboli — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

916.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): 2nd. & 3rd. degree burns of 35% of body area — 3½ months

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Conflagration in the home

20c. TIME OF INJURY Hour: 2:00 p.m. Month, Day, Year: January 15, 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Marlboro, Prince Georges, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul C. Van Natta M.D.

EXAMINER'S NAME (Type): Dr. Paul C. Van Natta

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: April 26, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-2-62

22c. NAME OF CEMETERY OR CREMATORY: Harmony

22d. LOCATION (City, town, or country) (State): Highland Park Md.

23. FUNERAL DIRECTOR: Rollins — ADDRESS: Myrtle K. Rollins 4339 Hunt Pl. N.E

24a. REC'D BY REGISTRAR DATE: MAY 2 '62

24b. REGISTRAR'S SIGNATURE: Clifton S. Hinman

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04968

CERTIFICATE OF DEATH

04965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince Geo.
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Mitchellville
c. LENGTH OF STAY IN 1b: 50 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchellville
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: NORA Middle: Nelson Last: Peach

4. **DATE OF DEATH**: Month: April Day: 18 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 13, 1882

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Jones Nelson

14. MOTHER'S MAIDEN NAME: Anne Rebecca Englar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Preston Peach Address: Same as # 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

DUE TO (b): Adeno Carcinoma of stomach — 6 mos.

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 16, 1962 to 18 Apr, 1962 that (I) (we) last saw the deceased alive on 14 Apr 1962 and that death occured at 2:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R B Sasscer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): R. B. Sasscer

22d. ADDRESS: Marlboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 21 April 1962

23c. NAME OF CEMETERY OR CREMATORY: Mt. Oak Cem.

23d. LOCATION (City, town or county) (State): Mitchellville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Gasch Funeral Home

ADDRESS: 4739 Baltimore Av. Hyatt. Md.

25a. REC'D BY REGISTRAR DATE: APR 24 '62

25b. REGISTRAR'S SIGNATURE

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04969

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04966

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Prince George's
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Kent Village
   d. STREET ADDRESS: 7220 Euclid ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert; Middle: William; Last: Peters

4. DATE OF DEATH: Month: April; Day: 12; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 22, 1920

9. AGE (In years last birthday): 42 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yard helper

10b. KIND OF BUSINESS OR INDUSTRY: B&O RR

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Phillip Fulmer Peters

14. MOTHER'S MAIDEN NAME: Florence May Kirkland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
    (If yes give war or dates of service): WW 11

16. SOCIAL SECURITY NO.: 210077008

17. INFORMANT: Thelma Dotson Peters, same as # 2
    Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Artery Occlusion

DUE TO (c): Hemorrhage of Atheromatous Plaque

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 4/12/62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-16-1962

22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEM

22d. LOCATION (City, town, or country) (State): BLADENSBURG, MARYLAND

23. FUNERAL DIRECTOR: W.W. Chambers Co. ADDRESS: Riverdale, Md

24a. REC'D BY REGISTRAR DATE: APR 17 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Harris

VR A1SME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04970

CERTIFICATE OF DEATH

04967

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 55 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5116 Flintridge Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Peters

4. DATE OF DEATH: Month: April — Day: 26 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 26, 1962

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Gordon A. Peters

14. MOTHER'S MAIDEN NAME: Ruth Virginia Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 76.5 Premature birth (5 mos pregnancy)
DUE TO (b): Premature rupture of membranes 12 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Umbilical cord tight around neck

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Yeer 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-26, 1962, to 4-26, 1962, that (I) (we) last saw the deceased alive on 4/26/62, 1962, and that death occured at 9:30 p.m., from the causes and on the date stated above.

22a. SIGNATURE: John Kehoe M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-2-62

22c. PHYSICIAN'S NAME (Type): Dr. John Kehoe

22d. ADDRESS: 6300 Riverdale Rd., Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 5/5/62

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Harry W. Penn, Jr., Administrator

25a. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krieger

2-046688

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04971

CERTIFICATE OF DEATH

04968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Adelphi~~ Cheverly
   c. LENGTH OF STAY IN 1b: 3 Hr
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adalphi
   d. STREET ADDRESS: 2515 Buck Lodge Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Alice — Middle: P — Last: Powell

4. **DATE OF DEATH**: Month: Apr. — Day: 22 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 5, 1888

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Brooklyn N.Y.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Carlton Prankard

14. MOTHER'S MAIDEN NAME: Martha C Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-44-2699

17. INFORMANT — Address: Marshall Powell Adelphi, Md. (Son)

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Massive Pulmonary Embolism
- DUE TO (b): Congestive Heart Failure
- DUE TO (c): Myocardial Fibrosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
- DUE TO: Coronary Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH: Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from March, 19 62 to 4-22, 19 62, that (I) ~~(we)~~ last saw the deceased alive on 4-22 19 62, and that death occured at 2:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R.D. Bauer M.D. M.D.

22b. DATE SIGNED: 4-22-62

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): R.D. Bauer, M.D.

22d. ADDRESS: 2513 Buck Lodge Road, Adelphi, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 24 1962

23c. NAME OF CEMETERY OR CREMATORY: Oakwood Cemetery

23d. LOCATION (City, town or county) (State): Falls Church, Va.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pearson Funeral Home Falls Church, Va.

25a. REC'D BY REGISTRAR — DATE: APR 25 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04972

CERTIFICATE OF DEATH

04969

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General ~~Lewis~~ Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lothian 02 X 2
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lewis — Middle: H — Last: Priset

4. DATE OF DEATH: Month: 4 — Day: 29 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-18-1885

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Emplyd Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: State Roads Comm.

11. BIRTHPLACE (County & State, or foreign country): Wellsboro, Pa.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Priset

14. MOTHER'S MAIDEN NAME: Rebecca Shaffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT Address: Mrs. Margaret Cox-------Lothian, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
526 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Hypertrophic Prostatitis (Bronchestasis) — 2+ yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive Cardio Vascular Disease with Failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-26, 1962 to 4-29, 1962 that (I) (we) last saw the deceased alive on 4-29 1962 and that death occured at 11:05 AM, from the causes and on the date stated above.

22a. SIGNATURE: Waldo B. Moyers M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-29-62

22c. PHYSICIAN'S NAME (Type): Waldo B. Moyers

22d. ADDRESS: 3503 Perry St. Mt. Rainier Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/4/62

23c. NAME OF CEMETERY OR CREMATORY: Wellsboro Cemetery

23d. LOCATION (City, town or county) (State): Wellsboro, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ritchie Bros. Fun'l Home-Upper Marlboro, Md.

25a. REC'D BY REGISTRAR: MAY 7 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04973

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04970

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: MARYLAND — D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: [illegible]
b. COUNTY: District of Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 300 Gallatin St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: Leo — Last: Radcliffe

4. DATE OF DEATH: Month: April — Day: 29, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 10, 1904

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Monocaster (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jesse Radcliffe

14. MOTHER'S MAIDEN NAME: Fannie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Florence Jackson Radcliffe, 119 You St. N.E. Address: Washington, D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): LACERATIONS, SPINAL CORD

812X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): FRACTURE) CERVICAL VERTEBRAE

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18:)

Struck by car while walking on Boulevard

20c. TIME OF INJURY: Hour: 10:45 p.m. — Month, Day, Year: 4/29 1962

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): U.S. Rte. #1

20f. (City or town): Murkirk — (County): P.G. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul C Van Natta M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/30/62

EXAMINER'S NAME (Type): PAUL C. VAN NATTA, M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5.4.62

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or country): WASHINGTON, D.C. (State):

23. FUNERAL DIRECTOR: [illegible] ADDRESS: 1870-9th Wash. D.C.

24a. REC'D BY REGISTRAR — DATE: MAY 3 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Timms

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04974 04971

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Avondale
c. LENGTH OF STAY IN 1b: 14 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2025 Woodreeve Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Avondale 49
d. STREET ADDRESS: 2025 Woodreeve Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle LESTER Last RICHARDS

4. DATE OF DEATH: Month April Day 11 Year 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 31 Oct. 1867

9. AGE (In years last birthday): 94 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Conductor

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R. R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: UNK.

14. MOTHER'S MAIDEN NAME: UNK.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705100060

17. INFORMANT: Mrs. Billie J. Cain Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): GANGRENE OF FEET — INTERVAL BETWEEN ONSET AND DEATH: 15 DAYS

450.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ARTERIOSCLEROSIS — 20 YRS.(?)

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. [redacted]

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 5 1959 to APR. 11 1962 that (I) (we) last saw the deceased alive on APR. 9 1962 and that death occurred at 8:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: J E Bowman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: APR. 14, 1962

22c. PHYSICIAN'S NAME (Type): J. E. Bowman, M.D.

22d. ADDRESS: 4021 — 18TH ST. N.E.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/12/62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Colmar Manor Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons Hyattsville, Maryland

25a. REC'D BY REGISTRAR DATE: APR 16 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [redacted] hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04975 (crossed out) 04972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residance before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 44 Cottage City
d. STREET ADDRESS: 3803 37th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: M — Last: Richardson

4. DATE OF DEATH: Month: April — Day: 25 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 18 Dec. 1889

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: City Post Office

11. BIRTHPLACE (County & State, or foreign country): Paterson N.J.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Richardson

14. MOTHER'S MAIDEN NAME: Virginia ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary G. Richardson, wife — Address: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart disease
DUE TO (c): Bilat. pulm. congestion

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 22nd, 1962, to April 25th, 1962, that (I) (we) last saw the deceased alive on April 25th 1962, and that death occured at 6.15AM from the causes and on the date stated above.

22a. SIGNATURE: Dr Till Bergemann — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Till Bergemann

22d. ADDRESS: 53A crescent Road greenbelt

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/28/62

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home Inc.

ADDRESS: Mt. Rainier Md.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L Kenna

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04976 04973

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ADSACORDA NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: VA
b. COUNTY: ~~ALEXANDRIA~~ FAIRFAX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ALEXANDER 83x-3
d. STREET ADDRESS: 310 ORVILLE ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EVA Middle: A. Last: ROBERTSON

4. DATE OF DEATH: Month: APRIL Day: 14 Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept 26, 1878

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (County & State, or foreign country): PRINCE GEO'S COUNTY Md

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: GEORGE DENNISON

14. MOTHER'S MAIDEN NAME: ALICE SUMMERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: GLADYS E HOLDEN
Address: 2230 Kearney St N.E.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease
420.0
DUE TO (b): Generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5 Jan, 1962 to 13 April, 1962 that (I) (we) last saw the deceased alive on 13 April 1962 and that death occured at 7A M, from the causes and on the date stated above.

22a. SIGNATURE: John Kehoe M.D.

22b. DATE SIGNED: 14 April 1962

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): JOHN KEHOE

22d. ADDRESS: 6300 RIVERDALE RD. RIVERDALE Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/17/62

23c. NAME OF CEMETERY OR CREMATORY: ADDISON CHAPEL CEM

23d. LOCATION (City, town or county) (State): SOUTH ALEXANDRIA PR GEO. CO MD

24 FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co

ADDRESS: 517-11th ST SE

25a. REC'D BY REGISTRAR DATE: APR 17 '62

25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04977

CERTIFICATE OF DEATH

04974

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 40 min
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 Cedar Heights
   d. STREET ADDRESS: 6221 Lee Place
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Baby — Middle: Girl — Last: Robinson

4. **DATE OF DEATH**: Month: April — Day: 16 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 16 April 1962

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min. 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roland F

14. MOTHER'S MAIDEN NAME: Maryl Helen Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: Same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH:
762.0
DUE TO (b): Possible dermoid tumor of neck
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/16/ 19 62 to 4/16/62 19 ..... that (I) (we) last saw the deceased alive on 4/16/62 19 ..... and that death occured at 2,50A M from the causes and on the date stated above.

22a. SIGNATURE: Salvatore Battiata M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Salvatore Battiata, M.D.

22d. ADDRESS: 7309 Riggs Rd - Hyatts

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: May 5, 1962

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county) (State): Cheverly, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr.

ADDRESS: Harry W. Penn, Jr., Administrator

25a. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

2-046516

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, in which case execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04978

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04975

1. PLACE OF DEATH
e. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berwyn Heights
d. STREET ADDRESS: 8916 59th., Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucian; Middle: —; Last: Rodriguez

4. DATE OF DEATH: Month: April; Day: 25; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 8, 1895

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): Porto Rico

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown Rodriguez

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give wer or dates of service): W.W. 1

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ludwig George Rodriguez, Address: 8219 16th. Ave., Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

DUE TO (b): Chronic Coronary Vascular disease — unknown

DUE TO (c): General arteriosclerosis — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None that I know

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Paul C Van Natta M.D.

EXAMINER'S NAME (Type): Paul C. Van Natta, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 4/26/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-1-62

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country): Arlington (State): Virginia

23. FUNERAL DIRECTOR: W. W. Chambers Co. ADDRESS: Riverdale, Md

24a. REC'D BY REGISTRAR DATE: APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

1

04979

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04976

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: USAF HOSPITAL, ANDREWS AIR FORCE BASE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: FAIRFAX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1800 St Marks Place
d. STREET ADDRESS: FAIRFAX VIRGINIA
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NORMAN — Middle ELLIOTT — Last ROGERS SR

4. DATE OF DEATH: Month APRIL — Day 20 — Year 1962

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 26 1887

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: HEATING

11. BIRTHPLACE (State or foreign country): AVONDALE, Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EBONEZER ROGERS

14. MOTHER'S MAIDEN NAME: ELLIOTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578072120

17. INFORMANT: (Son) Col Norman Rogers, Jr. — Address: 1800 St Marks Pl Fairfax, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Collapse — INTERVAL BETWEEN ONSET AND DEATH: less than 1 hr
DUE TO
(b): Metastatic Gastric Carcinoma
DUE TO
(c):

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 17 April, 1962, to 20 April, 1962, that ☐ (we) last saw the deceased alive on 20 April 1962, and that death occurred at 6:55PM from the causes and on the date stated above.

22a. SIGNATURE: Stanley R. Payne M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 20 April 62

22c. PHYSICIAN'S NAME (Type): STANLEY R. PAYNE, LT USN, MC

22d. ADDRESS: USAF HOSPITAL ANDREWS, ANDREWS AFB, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/27/62,

23c. NAME OF CEMETERY OR CREMATORY: COLUMBIA GARDENS

23d. LOCATION (City, town, or county) (State): ARLINGTON, VA.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] ARLINGTON FUNERAL HOME

ADDRESS: 3901 NO FAIRFAX DRIVE ARLINGTON 3, VA.

25a. REC'D BY REGISTRAR DATE: APR 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04980

CERTIFICATE OF DEATH

04977

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be e[illegible]d within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 1 day
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): PrinceGeorges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   e. STATE: Maryland
   b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 Cedar Heights
   d. STREET ADDRESS: 915 64th Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Baby — Middle: Girl "B" — Last: Ross

4. **DATE OF DEATH**: Month: April — Day: 29 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 28 April 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Edward Ross

14. MOTHER'S MAIDEN NAME: Wilma Mayo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

7545

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bilateral Pulmonary Atelectasis

DUE TO (c): Prematurity (Twin) B

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Yeer: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/28, 19 62 to 4/29, 1962, that (I) (we) last saw the deceased alive on 4/29 19 62, and that death occured at 7.38 PM from the causes and on the date stated above.

22a. SIGNATURE: Salvatore Battiata M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Salvatore Battiata

22d. ADDRESS: 7309 Riggs Rd., Hyattsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 5/4/62

23c. NAME OF CEMETERY OR CREMATORY: Prince George's Gen.Hosp.

23d. LOCATION (City, town or county) (State): Cheverly, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Administrator — ADDRESS

25a. REC'D BY REGISTRAR DATE: MAY 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2-046558

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04981 Item 8 Film G312 5/7/62 iwk 04978

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Suitland
c. LENGTH OF STAY IN 1b: 2 Month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suitland Nursing Hoame, Inc

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — D.C.
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Washington
d. STREET ADDRESS: 5303 Valley Rd., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Theodosia — Middle: — Last: Roudabush

4. DATE OF DEATH: Month: April — Day: 26, — Year: 19 62

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 5/4/1896 1894

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Moore

14. MOTHER'S MAIDEN NAME: Curry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT (Name, address): 5303 Valley Rd., S.E. Mrs. Eleanor Smith, Washington 27, D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Thrombosis	1 wk
DUE TO (b)	Cerebral Arteriosclerosis	4 mos.
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

33 2X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: — a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from March 27 19 62 to April 26, 19 62 that (I) (we) last saw the deceased alive on April 25 19 62, and that death occured at 6.25 A M, from the causes and on the date stated above.

22a. SIGNATURE: Frank S. Pellegrini M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/26/62

22c. PHYSICIAN'S NAME (Type): Frank S. Pellegrini

22d. ADDRESS: 3409 Ala Ave SE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: april 30-62

23c. NAME OF CEMETERY OR CREMATORY: arlington National

23d. LOCATION (City, town or county) (State): arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Semmons Bros

ADDRESS: 1661 Good Hope Rd SE

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Curtiss L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04982

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04979

Item 4 Film G312 5/3/62 iwk

1. PLACE OF DEATH
a. COUNTY: Prince George County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.C.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
d. STREET ADDRESS: 3708 Taylor Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alfred Middle: Tennyson Last: Rowley

4. DATE OF DEATH: Month: April Day: 26 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 10, 1911

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Rowley

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-05-4891

17. INFORMANT: (Wife) Address: Mrs. Ruth Rowley - - Same as 2d.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Coronary Vascular Disease — 4 yrs

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): None that of know

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Natural Causes

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul C Van Natta M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type): Dr. Paul C. Van Natta

Address (Street, city, town, or county)

April 27, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/30/62

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

22d. LOCATION (City, town, or country) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR: Malley's Funeral Home Inc.

ADDRESS: Mt. Rainier Md.

24a. REC'D BY REGISTRAR DATE: APR 30 '62

24b. REGISTRAR'S SIGNATURE: Clarence E. Frame

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04983 — Information from birth cert. — 04980

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Hyattsville
d. STREET ADDRESS: 4310 Baltimore Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Royal

4. DATE OF DEATH: Month: April — Day: 16 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 14 April 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days: 2 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clifford Arden Royal

14. MOTHER'S MAIDEN NAME: Donetta Rea Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Clifford Royal Same as # 2 Father

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 773 .5 Prematurity —
DUE TO (b): with Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Respiratory Distress Synd —

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 11, 1962 to April 16, 1962, that (I) (we) last saw the deceased alive on April 16 19 62, and that death occured at 11.15PM from the causes and on the dete stated above.

22a. SIGNATURE: Salvatore Battiata M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: April 17, 1962.

22c. PHYSICIAN'S NAME (Type): Dr. Salvatore Battiata

22d. ADDRESS: 7309 Baltimore Ave Hyatts—

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/12/62

23c. NAME OF CEMETERY OR CREMATORY: Evergreen

23d. LOCATION (City, town or county) (State): Bladensburg Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Alfred S. Bugg

ADDRESS: Hyattsville, Md

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2-148532

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04984 — 04981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: PRINCE GEORGE — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
   c. LENGTH OF STAY IN 1b: adm. 8-13-1960
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): LAUREL SANITARIUM

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
   d. STREET ADDRESS: 3909 Woodbine Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

15542

3. **NAME OF DECEASED** (Type or print): First: JANET — Middle: S. — Last: RUTTER

4. **DATE OF DEATH**: Month: 4 — Day: 24 — Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-16-1874

9. AGE (In years last birthday): 87 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: — UNKNOWN

14. MOTHER'S MAIDEN NAME: HENRIETTA BARNES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Charles M. Little, (Daughter)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute bronchitis (purulent) 500 — INTERVAL BETWEEN ONSET AND DEATH: 2 days
500X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile psychosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-13-, 1960 to 4-24-, 1962 that (I) (we) last saw the deceased alive on 4-24-1962, and that death occured at 5:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Erika P. Kraemer M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 4-24-62
22c. PHYSICIAN'S NAME (Type): ERIKA P. KRAEMER
22d. ADDRESS: LAUREL SANITARIUM LAUREL Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4-28-1962
23c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY
23d. LOCATION (City, town or county) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Dawler's Sons
ADDRESS: [illegible] Wash. D.C.
25a. REC'D BY REGISTRAR DATE: APR 27 '62
25b. REGISTRAR'S SIGNATURE: Clinton E. Frank

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04985 04982

1. PLACE OF DEATH
a. COUNTY PRINCE GEORGES, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville
d. STREET ADDRESS 3507 79th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Irene Middle Joy Last Sanger
4. DATE OF DEATH Month April Day 13 Year 1962
5. SEX Female
6. COLOR OR RACE Cau.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1 Feb 1962
9. AGE (In years last birthday) — yrs.
IF UNDER 1 YEAR Months 2 Days 12
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most af working life, even if retired) Not Applicable
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Benjamin Sanger
14. MOTHER'S MAIDEN NAME Mildred (NMI) Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Not applicable
17. INFORMANT Benjamin Sanger Address 3507 79th Ave Forestville, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease — INTERVAL BETWEEN ONSET AND DEATH 2 mos
754.5
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost.
DUE TO (b) Mongolism — 2 mos
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12 April 1962 to 13 April 1962 that (I) (we) last saw the deceased alive on 13 April 1962 and that death occurred at 2208 M, from the causes and on the date stated above.

22a. SIGNATURE John A. Moore M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 13 April 1962
22c. PHYSICIAN'S NAME (Type) John A. Moore
22d. ADDRESS 5571 Auth Road Camp Springs, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 4/16/62
23c. NAME OF CEMETERY OR CREMATORY D.C. Lodge Cem
23d. LOCATION (City, town, or county) (State) Wash., DC

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert Thomas Funeral Home 4217-9th St. N.W.
25a. REC'D BY REGISTRAR DATE APR 17 '62
25b. REGISTRAR'S SIGNATURE Arthur L. Krause

2:009647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1
FOR STATE HEALTH DEPT.

M

X

I

0

2

04983

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04983

1. PLACE OF DEATH
a. COUNTY: Prince Georges County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
c. LENGTH OF STAY IN 1b: 50 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4604 Davis Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 1 Suitland
d. STREET ADDRESS: 4604 Davis Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle COLUMBIA Last SCHLORB

4. DATE OF DEATH: Month April Day 25, Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 26, 1889.

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer, (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Cemetery

11. BIRTHPLACE (State or foreign country): Springville, Virginia. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Leonard Schlorb

14. MOTHER'S MAIDEN NAME: Maryella Donaldson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give wer or dates of service): WW I

16. SOCIAL SECURITY NO.: 577-22-9780

17. INFORMANT: Viola Marie Schlorb, Address 4604 Davis Ave., Suitland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Coronary Vascular — Unknown
DUE TO
(c) disease - General Arteriosclerosis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Natural Causes

20c. TIME OF INJURY: Hour a.m. p.m. None Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Paul C Van Natta M.D.

EXAMINER'S NAME (Type): PAUL C. VAN NATTA, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): DATE SIGNED April 25, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4-30-62

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

22d. LOCATION (City, town, or country) (State): ARLINGTON, VIRGINIA,

23. FUNERAL DIRECTOR ADDRESS: W. W. CHAMBERS CO., Riverdale, Md.

24a. REC'D BY REGISTRAR DATE APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, he execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04987

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04984

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Riverdale
d. STREET ADDRESS: 5301 Quintana St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle PHILLIP Last SHACKLEFORD

4. DATE OF DEATH: Month April Day 13 Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 5,1920

9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Fireman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Berryville, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mervim Howard Shackleford

14. MOTHER'S MAIDEN NAME: Lula Mae Smallwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: 229-34-7630

17. INFORMANT: Christian Scholly Address: 6006 BlackFires Cir. Baltimore, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Drowning
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): In an automobile that ran off the bank of the river

20c. TIME OF INJURY Month, Day, Year: Hour 4:15 p.m. xx 4/13/ 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River

20f. (City or town) Queen Ann Bridge (County) P. G. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES I. BOYD

Address (Street, city, town, or county):

DATE SIGNED: 4/14/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/17/62

22c. NAME OF CEMETERY OR CREMATORY: Green Hill

22d. LOCATION (City, town, or country) (State): Berryville, Va.

23. FUNERAL DIRECTOR: F. Gasch's Sons

ADDRESS: Hyattsville, Md.

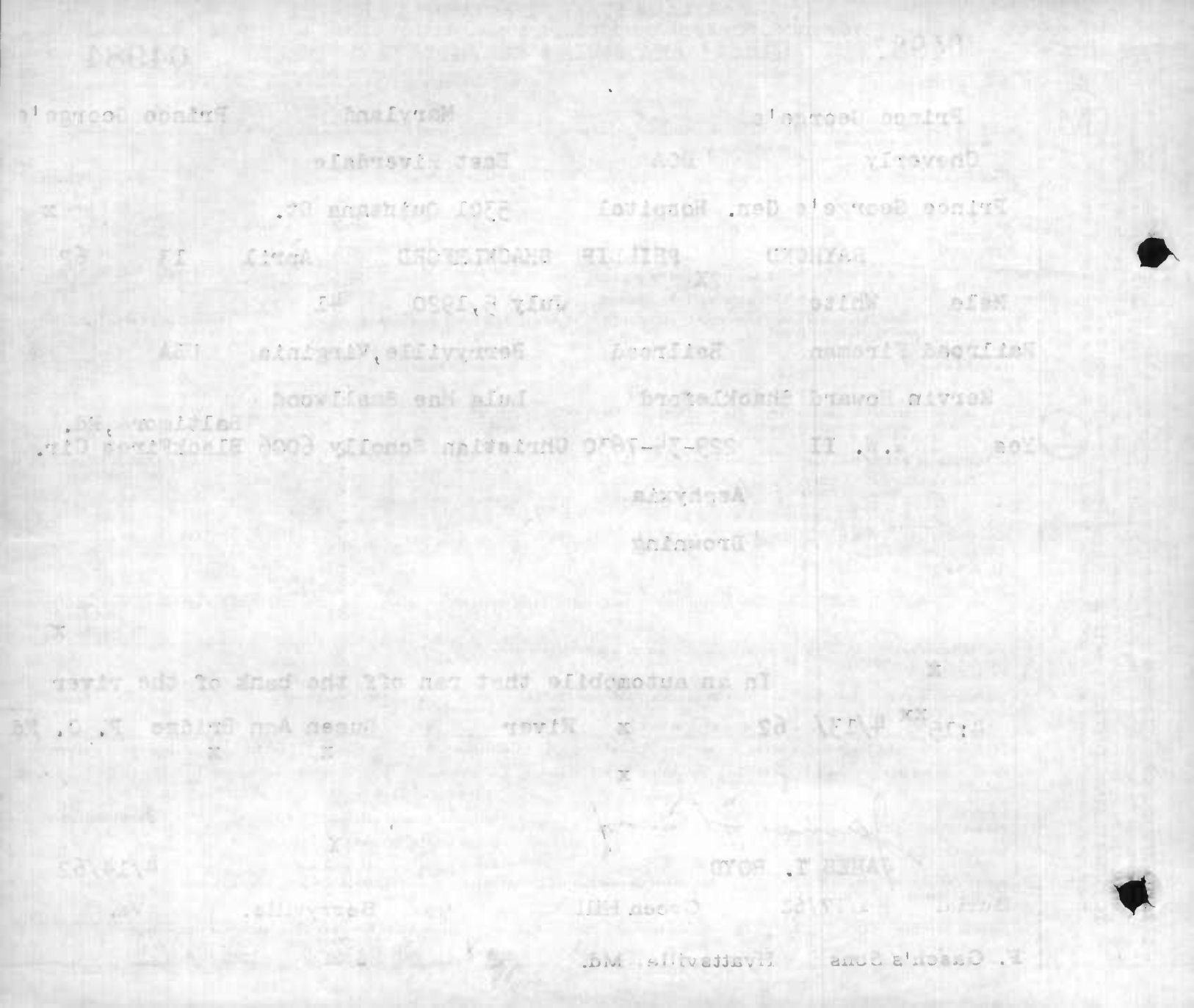
24a. REC'D BY REGISTRAR DATE APR 18 '62

24b. REGISTRAR'S SIGNATURE: Cirthus L. Mauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, which in any event within 72 hours after death.

VR A15ME
5M 1/62



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04988

CERTIFICATE OF DEATH

Reg. Dist. No. 04985

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
c. LENGTH OF STAY IN 1b: 29 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5020-38th AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PR. GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 62 HYATTSVILLE
d. STREET ADDRESS: 5020-38TH AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle — Last SIEGEL

4. DATE OF DEATH: Month APRIL Day 16 Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-20-1884

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MUSICIAN

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GETCHELL SIEGEL

14. MOTHER'S MAIDEN NAME: RIVA MARCUS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 220-32-7335

INFORMANT: OSCAR SIEGEL — Address: FT. LAUDERDALE, FLA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): THROMBOSIS, CEREBRAL — INTERVAL BETWEEN ONSET AND DEATH: 1 WEEK
DUE TO
(b): ARTERIOSCLEROSIS, GENERALIZED — 3 MONTHS
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 1, 1962, to APRIL 16, 1962, that I last saw the deceased alive on APR. 16, 1962, and that death occurred at 1 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. N. Sugar M.D. — ADDRESS (Street, city or town, state): 4637 EASTERN AVE WASHINGTON 18, DC — DATE SIGNED: 4/16/62

PHYSICIAN'S NAME (Type): SAMUEL J. N. SUGAR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4/17/62

22c. NAME OF CEMETERY OR CREMATORY: NAT'L MEM. PARK

22d. LOCATION (City, town, or county) (State): FALLS CHURCH VA

23. FUNERAL DIRECTOR'S SIGNATURE: Gladding Funeral Home — ADDRESS: 4217-9th Nw

24a. REC'D BY REGISTRAR DATE: APR 17 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04989

CERTIFICATE OF DEATH

04986

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

08

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 1 yr., 5 mos., & 27 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 222 F. St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Luther — Middle: — — Last: Simms

4. DATE OF DEATH: Month: 4 — Day: 22 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 2/28/01

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed (unknown)

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): S.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Decedent — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic glomerulonephritis — ?
DUE TO (c):

592X

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis; pulmonary abscess, right upper lobe; cerebro-vascular accidents, bilateral

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/26/ 7:15 1960, to 4/22/, 1962., that (I) (we) last saw the deceased alive on 4/22/ 19 62., and that death occured at p. M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 4/22/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M.D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 4-27-62

23c. NAME OF CEMETERY OR CREMATORY: Lincoln Mem.

23d. LOCATION (City, town or county) (State): Suitland Rd Md

24 FUNERAL DIRECTOR'S SIGNATURE: H.S. Washington & Son — ADDRESS: 4925 Peare Ave NE

25a. REC'D BY REGISTRAR DATE: APR 27 '62

25b. REGISTRAR'S SIGNATURE

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04990

CERTIFICATE OF DEATH

04987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death occurs. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
1SM 7/61

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (RURAL)
c. LENGTH OF STAY IN 1b: 1 yr. 9 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 701 - E. Capitol
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Myrtle — Middle: B. — Last: Slagle

4. **DATE OF DEATH**: Month: April — Day: 19 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 3, 1896

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carolina, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George O. Loving

14. MOTHER'S MAIDEN NAME: Sarah Dishman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: -

17. **INFORMANT** Address: Decedent

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart disease with decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 months

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic pyelonephritis; Generalized arteriosclerosis with chronic brain syndrome.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 19 1960, to April 19, 1962, that (I) ~~(we)~~ last saw the deceased alive on April 19 1962, and that death occured at 7:05 P M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 4/19/62

22c. PHYSICIAN'S NAME (Type): Moe Weiss

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 27-62

23c. NAME OF CEMETERY OR CREMATORY: Loving Family Cem.

23d. LOCATION (City, town or county): Havertons (State): Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Marks Funeral Home - by J.P. Sparrow ADDRESS: Tappahannock Va.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04991 04988

1 M 50 I 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US AIR FORCE HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X UPPER MARLBORO
d. STREET ADDRESS: ROUTE #4, BOX 1094
e. IS RESIDENCE ON A FARM? YES XX NO

3. NAME OF DECEASED (Type or print): First BRIAN — Middle THORNTON — Last SMITH

4. DATE OF DEATH: Month APRIL — Day 2 — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 31 MARCH 1962

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): PRINCE GEORGES, MARYLAND

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: DELBERT THORNTON SMITH

14. MOTHER'S MAIDEN NAME: CAROLYN ANN CRAIG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: DELBERT T SMITH (FATHER) — Address: SAME AS ITEM #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 48 HOURS

760.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): BRAIN DAMAGE — 48 HOURS

DUE TO (c): FRACTURED SKULL — 48 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CRANIOTABES

19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): SKULL FRACTURE INCURRED DURING SPONTANEOUS DELIVERY

20c. TIME OF INJURY Hour 9:59 XX p.m. Month, Day, Year MARCH 31, 19 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): USAF HOSPITAL

20f. (City or town) (County) (State): ANDREWS AFB, PRINCE GEORGES, MD

21. **I certify** that X (this hospital) attended the deceased from 31 MARCH, 19 62 to 2 APRIL, 19 62, that (I) XXX last saw the deceased alive on 2 APRIL 19 62, and that death occured at 1030P from the causes and on the date stated above.

22a. SIGNATURE: John A. Moore M.D.

22c. PHYSICIAN'S NAME (Type): JOHN A MOORE, Major USAF MC

ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2 APRIL 1962

22d. ADDRESS: USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3/6-1962

23c. NAME OF CEMETERY OR CREMATORY: ARL NAT CEMETERY

23d. LOCATION (City, town or county) (State): ARLINGTON VA

24 FUNERAL DIRECTOR'S SIGNATURE: W W Chambers Co

ADDRESS: 517-11th ST SE WASH (3) DC

25a. RECD BY REGISTRAR DATE: APR 6 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2-068362

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04932 04991

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1417 Holbrook Street N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence; Middle: William; Last: Southard
4. DATE OF DEATH: Month: April; Day: 16; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 5, 1899
9. AGE (If years last birthday): 62 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Oil Burner
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: Columbus Benjamin Southard
14. MOTHER'S MAIDEN NAME: Laura Virginia Wheakley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 578-07-7563
17. INFORMANT: Anna Cecilia Southard, same as # 2 — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute congestive heart failure	
DUE TO (b)	Coronary artery disease- severe	
DUE TO (c)	Cardiovascular renal disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: April 17, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-20-62
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR: W. W. Chamberlin Co. ADDRESS: Riverdale, Md.
24a. REC'D BY REGISTRAR DATE: APR 19 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04993

04989

1

FOR STATE HEALTH DEPT.

M

77

1

2

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1. PLACE OF DEATH
a. COUNTY: Prince George's
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 606 Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Steven Middle: Richard Last: Sproles

4. DATE OF DEATH: Month: April Day: 24, Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 10, 1957

9. AGE (In years last birthday): 5 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lewis Paul Sproles

14. MOTHER'S MAIDEN NAME: Thelma M. Dunsmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give were or dates of service): None

17. INFORMANT: Mr. Lewis P. Sproles, Address 606 Main St., Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INTRACRANIAL INJURY and FRACTURE PELVIS

S12X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Struck by truck in street

20c. TIME OF INJURY Month, Day, Year: Hour 2:00 p.m. April 24, 62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 500 Blk. Main St.

20f. (City or town): Laurel (County): (State): Maryland.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Paul C. VanNatta M.D.

EXAMINER'S NAME (Type): PAUL C. VAN NATTA, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 4/25/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/28/62

22c. NAME OF CEMETERY, OR CREMATORY: Sharon Missionary Baptist Church Cemetery

22d. LOCATION (City, town, or country): Howard Co., (State): Md.

23. FUNERAL DIRECTOR: [illegible]

ADDRESS: 550 Wash. Blvd., Laurel, Md.

24a. REC'D BY REGISTRAR DATE: APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Howard

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04994 (top) 04990

1

M

77

I

0

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges County — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 18 Days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Prince Georges General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince Georges County
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beltsville
   d. STREET ADDRESS: 41 Maryland Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Thelma — Middle: M. — Last: Sydnor

4. **DATE OF DEATH**: Month: April — Day: 24, — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-11-22

9. AGE (In years last birthday): 39 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Richmond Cty., Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Luther Moss

14. MOTHER'S MAIDEN NAME: Nola L. Sanders

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Melvin Sydnor, Sr. — Address: Maryland Ave., Beltsville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) MASSIVE INTERNAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO (b) DIFUSE CARCINOMATOSIS

DUE TO (c) SQUAMOS CELL CARCINOMA

191.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 6, 1962, to April 24, 19 62 that (I) (we) last saw the deceased alive on April 24, 19 62, and that death occured at 8:00 A.M. the causes and on the date stated above.

22e. SIGNATURE: Peter Duus M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-25-62

22c. PHYSICIAN'S NAME (Type): Dr. Peter Duus

22d. ADDRESS: 6124 Central Ave., Capitol Hgts., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-27-62

23c. NAME OF CEMETERY OR CREMATORY: Rappahannock Baptist

23d. LOCATION (City, town or county) (State): Newland, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Wm. R. Sanford — ADDRESS: Montross, Va.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Cathryn L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04933

1. PLACE OF DEATH
a. COUNTY: Prince Georges Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): E. Hyattsville, Md. 52
d. STREET ADDRESS: 625 - Floridan St. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Fern Middle: Edith Last: Snader
4. DATE OF DEATH: Month: April Day: 22 Year: 1962

5. SEX: F.
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Jan. 20 - 1890
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Washington Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Karew
14. MOTHER'S MAIDEN NAME: Johanna Hilbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Marion T. Patrick Address: 1432 Quebec St. E. Hyattsville Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinoma left breast — 2 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/2, 1958, to 4/22, 1962, that (I) (~~we~~) last saw the deceased alive on 4/21 1962, and that death occured at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: M.F. Ottman M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/22/62
22c. PHYSICIAN'S NAME (Type): M. F. OTTMAN
22d. ADDRESS: 401 Kennedy St NW DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 25-1962
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St. S.E. DC
25a. REC'D BY REGISTRAR DATE: APR 24 '62
25b. REGISTRAR'S SIGNATURE: Curtiss L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04996 **CERTIFICATE OF DEATH** 04993

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince George — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 46 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince George
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47 Mt Rainier
   d. STREET ADDRESS: 1 4526 32nd S t.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Guiseppe — Middle: — Last: Vincelli

4. **DATE OF DEATH**: Month: Apr. — Day: 22 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 18, 1930

9. AGE (In years last birthday): 32 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Layer

10b. KIND OF BUSINESS OR INDUSTRY: Laying bricks for Hilleton Co.

11. BIRTHPLACE (County & State, or foreign country): Campobasso, Italy

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Michele Vincelli

14. MOTHER'S MAIDEN NAME: Mariantonia Pietrantonica

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 578-50-1463

17. INFORMANT: Aldina Vincelli — Address: above

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Peritonitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Multiple perforations and fistulae of large and small intestine

DUE TO (c): Adhesions, multiple, post-surgical

INTERVAL BETWEEN ONSET AND DEATH: 1 WEEK — Weeks / Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Mar. 7, 1962, to Apr. 22, 1962, that (I) (we) last saw the deceased alive on Apr. 21 1962, and that death occured at 12:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John H. Bayly M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): JOHN H. BAYLY

22d. ADDRESS: 1835 Eye N.W., WASH 6 D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/25/62

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kelly's Funeral Home Inc.

ADDRESS: Mt. Rainier Md

25a. REC'D BY REGISTRAR DATE: APR 26 '62

25b. REGISTRAR'S SIGNATURE: Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04997 **CERTIFICATE OF DEATH** 04994

1. **PLACE OF DEATH**
a. COUNTY Prince George
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b 7 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant
d. STREET ADDRESS 510 68th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print) First Harold Middle E Last Walker

4. **DATE OF DEATH** Month Apr. Day 10 Year 19 62

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH July 7,1900

9. AGE (In years last birthday) 61 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodworking

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Edward Walker

14. MOTHER'S MAIDEN NAME Mary Frances Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Mrs Pauline Walker-wife 510-68th ave

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia left Upper Lobe — INTERVAL BETWEEN ONSET AND DEATH 3 wks
490X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchogenic Carcinoma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/3/62, 19..., to Apr. 10, 1962, that (I) (we) last saw the deceased alive on ...19 62, and that death occured at 5:35P/M from the causes and on the date stated above.

22a. SIGNATURE George William Ware M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Dr. George William Ware

22d. ADDRESS 1835 16th St NW, Washington, D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE THEREOF 4-13-62

23c. NAME OF CEMETERY OR CREMATORY Cedar Hill

23d. LOCATION (City, town or county) (State) Suitland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home

ADDRESS Washington DC

25a. REC'D BY REGISTRAR DATE APR 13 '62

25b. REGISTRAR'S SIGNATURE Clifton S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04998

CERTIFICATE OF DEATH

04995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cottage City, Md.
   c. LENGTH OF STAY IN 1b: 6 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3708 38th Avenue

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 44 Cottage City
   d. STREET ADDRESS: 3708 38th Ave,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Sue — Middle: — Last: Wallin

4. **DATE OF DEATH**: Month: April — Day: 30 — Year: 1962

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 1880

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Chicago, Illinois

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: L. P. A. Wallin

14. MOTHER'S MAIDEN NAME: Louisa M. Frickson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** — Address: Elvira W. Greenwood same as #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): chronic congestive failure — INTERVAL BETWEEN ONSET AND DEATH

410X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Aortic & mitral valve disease

DUE TO (c): Hypertension cardio renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: George J. Hageage M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/2/62

22c. PHYSICIAN'S NAME (Type): Dr. George J. Hageage

22d. ADDRESS: 3717 38th Ave., Cottage City, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/3/62

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town, or county): Suitland, (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons — ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 4 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Thomas

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04999

CERTIFICATE OF DEATH

04996

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Prince Georges — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parkland
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 35--Maryland Ave. S. E.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Pr. Geo.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Parkland
   d. STREET ADDRESS: 1 35--Maryland Ave., S.E.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: REV. — Middle: ROBERT — Last: L. WHITTENBURG

4. **DATE OF DEATH**: Month: April — Day: 17th — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 21, 1882

9. AGE (In years last birthday): 79 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas A. Whittenburg

14. MOTHER'S MAIDEN NAME: Mary E. Whitehurst

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Sarah M. Whittenburg -35 Maryland Ave Parkland Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Occlusion	Instant
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Coronary arteriosclerosis	unknown
DUE TO (c)	General Arteriosclerosis	Unknown

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none of note

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): natural Causes

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March 1, 1962 to Apr. 17, 1962 that (I) (~~we~~) last saw the deceased alive on Apr. 16 1962, and that death occured at 6 P M, from the causes and on the date stated above.

22a. SIGNATURE: Paul C Van Natta M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 17th 1962

22c. PHYSICIAN'S NAME (Type): Dr. Paul C. Van Natta

22d. ADDRESS: 5440--Silver Hill Rd., Suitland Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 20, 1962

23c. NAME OF CEMETERY OR CREMATORY: Epiphany Cemetery

23d. LOCATION (City, town or county) (State): Forestville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Lemmon Bros. — ADDRESS: 1661--Good Hope Rd., SE Washington 20 DC

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Clifton L. Noyes

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04937

1. PLACE OF DEATH
a. COUNTY: Prince George County — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Forestville
d. STREET ADDRESS: 5419 Pine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ralph — Middle: Allen — Last: Williams

4. DATE OF DEATH: Month: April — Day: 27, — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 27, 1912

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus Operator

10b. KIND OF BUSINESS OR INDUSTRY: D.C. Transit

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George A. Williams

14. MOTHER'S MAIDEN NAME: Mary Alice Spell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: 578-10-7358

17. INFORMANT (Wife) Address: Mrs. Doris Williams - Same as 2d

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Coronary Artery Disease — Unknown
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): natural Causes

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul C VanNatta, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. Paul C. VanNatta

Address (Street, city, town, or county):

DATE SIGNED: April 27, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-30-1962

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln

22d. LOCATION (City, town, or country) (State): Prince George County Md

23. FUNERAL DIRECTOR: Robert A Mattingly

ADDRESS: 131-11th St Washington DC

24a. REC'D BY REGISTRAR DATE: APR 30 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1
FOR STATE HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04938

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residance before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
d. STREET ADDRESS: 9120 Fowler Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter Middle: Lanier Last: Wilson Jr
4. DATE OF DEATH: Month: April Day: 3 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 11, 1942
9. AGE (In years last birthday): 20 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10b. KIND OF BUSINESS OR INDUSTRY: Barber
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Walter Lanier Wilson Sr.
14. MOTHER'S MAIDEN NAME: Helen Margaret Curtin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 216-40-9534
17. INFORMANT Address: Walter Lanier Wilson Sr., same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage and shock — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Crushed skull

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in an automobile that overturned
20c. TIME OF INJURY Hour a.m.: 12:30xx Month, Day, Year: 4/3/62
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road
20f. (City or town): Lanham (County): P. G. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I, Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/3/62
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-6-1962
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
22d. LOCATION (City, town, or country) (State): Washington, D.C

23. FUNERAL DIRECTOR ADDRESS: W. W. Chambers Co Riverdale, Md
24a. REC'D BY REGISTRAR DATE: APR 6 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05002

CERTIFICATE OF DEATH

04999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Prince Georges County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Upper Marlboro
d. STREET ADDRESS: R.F.D. Box 3703
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Harrison — Middle: Wade — Last: Windsor

4. DATE OF DEATH: Month: April — Day: 8, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 3-2-99

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN WINDSOR

14. MOTHER'S MAIDEN NAME: AGNES WINDSOR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: 215-14-7127

17. INFORMANT — Address: Wilson Windsor, Upper Marlboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1. Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): 2. Congestive Heart Failure — Chronic

DUE TO (c): 3. Left Coronary Thrombosis (fresh)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-3- 1962., to 4-8-, 19.62 that (I) (we) last saw the deceased alive on 4-8-19.62., and that death occured at 5:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. Clark Holmes M.D.

22b. DATE SIGNED: 4/9/62

22c. PHYSICIAN'S NAME (Type)

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22d. ADDRESS: Upper Marlboro Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-11-62

23c. NAME OF CEMETERY OR CREMATORY: Mt CARMEL

23d. LOCATION (City, town or county) (State): Upper MARLBORO, MD.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hunt Funeral Home, Waldorf, Md.

25a. REC'D BY REGISTRAR DATE APR 12 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

M

77

I

0

16

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05003

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05000

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Washington 27, D.C.
d. STREET ADDRESS: 7800 Largo Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: M.aria — Last: Windsor
4. DATE OF DEATH: Month: April — Day: 10 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5/28/87
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Tenent, ~~Own~~ Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Henry Roberson
14. MOTHER'S MAIDEN NAME: Georgeiana (nee Tucker) ~~Last Name Unknown~~
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT (Name, address): Clarence Windsor Route # 3 Box 604E Edgewater, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiovascular renal disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of the right hip

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell on the bed room floor
20c. TIME OF INJURY Hour e.m.: 1:00 ~~xx~~ — Month, Day, Year: 3/23 4/24/ 19 62
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Largo (County) P. G. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: James L. Boyd M.D.
EXAMINER'S NAME (Type): JAMES L. BOYD, M.D. Address (Street, city, town, or county)
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 4/10/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/13/62
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or country) (State): Bladensburg Maryland

23. FUNERAL DIRECTOR — ADDRESS: Ritchie Bros. Fun'l Home-Upper Marlboro Md.
24a. REC'D BY REGISTRAR DATE: APR 23 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Thrasher

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

3 33

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05004 Item 2 FIL G213 5/21/62 iwk 05001

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Suitland, Md. Wash. 23, D.C.
c. LENGTH OF STAY IN this place: 4-24-62 - 4-25-62
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suitland Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 1 47X-3
d. STREET ADDRESS: 3109 Nichols Ave. S.E. (Address White/Hall/Steck)
IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First: John — Middle: C — Last: Witt

4. **DATE OF DEATH**: Month: 4 — Day: 25 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 7-26-81

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroader

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Witt

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 705-09-4266

17. INFORMANT: Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA, colon c generalized metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

153.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/11, 1962, to 4/25, 1962, that (I) (we) last saw the deceased alive on 4/25, 1962, and that death occured at 7:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Leo H. Mugmon M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): LEO H. MUGMON M.D.

22d. ADDRESS: 3109 NICHOLS AVE S E

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-29-62

23c. NAME OF CEMETERY OR CREMATORY: Hill Grove Cemetery

23d. LOCATION (City, town or county) (State): CONNELLSVILLE, PENNA.

24 FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: Wash. D. C.

25a. REC'D BY REGISTRAR DATE: APR 27 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05005

05002

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH — a. COUNTY: Prince George — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: PR. GEO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 CAMP SPRINGS
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 5564 - Branch Ave SE	d. STREET ADDRESS: 5564 - Branch Ave SE — e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)	First: Romey	Middle: FRANKLIN	Last: Wood	4. DATE OF DEATH	Month: April	Day: 3	Year: 1962	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 6-JAN. 1882	9. AGE (In years last birthday): 80 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired	10b. KIND OF BUSINESS OR INDUSTRY: FARMER	11. BIRTHPLACE (State or foreign country): MARYLAND	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Thomas F. Wood		14. MOTHER'S MAIDEN NAME: MIRIAH E. BURGESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address: FRANCES E. Wood - SAME AS #2	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Vascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

(b): General Arterio Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Natural Causes			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 3, 1962, to Apr 5, 1962 that (I) (we) last saw the deceased alive on Apr 3 1962, and that death occurred at 10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul C Van Natta M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): PAUL C VAN NATTA	22d. ADDRESS: 5440 Silver Hill Rd Washington 28 DC		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: April 6-62	23c. NAME OF CEMETERY OR CREMATORY: St. Barnabas Cemetery	23d. LOCATION (City, town, or county) (State): Oxon Hill Md
24. FUNERAL DIRECTOR'S SIGNATURE: Lemmon Bros	ADDRESS: 1661 - Good Hope Rd SE Wash. 20 DC	25a. REC'D BY REGISTRAR DATE APR 6 '62	25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G311 4/26/62 mh

05006

CERTIFICATE OF DEATH

Item 2 Film G312 5/3/62 mh

Reg. Dist. No. 05003

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 5 Years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: CARROLL MANOR (4922 LaSalle Rd)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. D.C.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON, MARYLAND Washington
d. STREET ADDRESS: 2002 P St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZA Middle P. Last WORTHINGTON

4. DATE OF DEATH: Month APRIL Day 20 Year 1962

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 26, 1865

9. AGE (In years last birthday): 96 97 yrs.
IF UNDER 1 YEAR: Months 11 Days 26
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): GEORGETOWN

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES WORTHINGTON

14. MOTHER'S MAIDEN NAME: REBECCA BRITTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: SISTER AGNES PATRICIA Address: (CARROLLMANOR)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE WITH CONgestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b) GENERALIZED ARTERIOSCLEROSIS — 4 yrs.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I ottended the deceased from Nov. 15, 1958, to April 20, 1962, thot I last saw the deceased olive on April 20, 1962, and thot deoth occurred at 9 A. M, from the causes ond on the date stated above.

ACTUAL SIGNATURE: Thomas F. Collins M.D.
ADDRESS (Street, city or town, stote): 322 H. St. N.E.
DATE SIGNED: April 20, 1962

PHYSICIAN'S NAME (Type): Thomas F. Collins M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 4/23/62

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek

22d. LOCATION (City, town, or county) (State): Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler Sons ADDRESS: 1756 Pa. Ave. N.W.

24a. REC'D BY REGISTRAR DATE: APR 23 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05007 (M) 05004

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: PRINCE GEORGES — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US AIR FORCE HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: PRINCE GEORGES
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 28 ANDREWS AIR FORCE BASE
   d. STREET ADDRESS: 1 CONCORD AVENUE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ADOLPH — Middle: — Last: ZAHARA

4. **DATE OF DEATH**: Month: APRIL — Day: 29 — Year: 19 62

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2 AUGUST 1923

9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AIRMAN

10b. KIND OF BUSINESS OR INDUSTRY: US AIR FORCE

11. BIRTHPLACE (County & State, or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): 1943-1962

16. SOCIAL SECURITY NO.: 017-18-5555

17. INFORMANT: Records Andrews A. F. Base — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): FRACTURED SKULL AND INTRACRANIAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 936.6

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): ALLEGEDLY INVOLVED IN ALTERCATION

20c. TIME OF INJURY: Hour 6:30 p.m. — Month, Day, Year: APR 29 19 62

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): TAVERN

20f. (City or town): BALTIMORE (County): BALTIMORE (State): MD

21. **I certify** that (I) XXXXXXXX attended the deceased from 29 APRIL, 19 62 to 29 APRIL, 19 62, that (I) XXX last saw the deceased alive on DOA 19 62, and that death occured at 845 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Kenneth A. Grigg, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 29 APRIL 1962

22c. PHYSICIAN'S NAME (Type): KENNETH A GRIGG, Capt USAF MC

22d. ADDRESS: USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): SHIP

23b. DATE THEREOF: 5-1-62

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City, town or county): PANAMA CITY (State): FLA

24 FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co — ADDRESS: 517-11th ST SE.

25a. REC'D BY REGISTRAR DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Clifton E. Krause

VR A15 (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05008

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05005

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 66 East Riverdale
d. STREET ADDRESS: 5509 59th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Ignatz — Last: Zmayuski

4. DATE OF DEATH: Month: Apri, — Day: 18 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/30/72

9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rigger

10b. KIND OF BUSINESS OR INDUSTRY: Plant maintanance

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Adam Xy Zmyuski

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Joseph Julius Zane, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary infarct	36 hrs
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Phlebthrombitis	2 days
DUE TO (c)	Fracture of right hip	4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General arteriosclerosis, congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell in yard of home

20c. TIME OF INJURY — Hour e.m.: 8:15 xxx — Month, Day, Year: 4/14/62

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) East Riverdale (County) P. G. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: April 18, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-21-1962

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem

22d. LOCATION (City, town, or country) (State): Bladensburg, Maryland

23. FUNERAL DIRECTOR: W.W. Chambers Co — ADDRESS: Riverdale, Maryland

24a. REC'D BY REGISTRAR DATE: APR 23 '62

24b. REGISTRAR'S SIGNATURE

VR A15ME
5M 1/62